

UnitedHealthcare PPO Dental
UnitedHealthcare Insurance Company
Certificate of Coverage

FOR: Louisiana State University and Agricultural and Mechanical College

DENTAL PLAN NUMBER: UHC Custom LSU Basic Plan PS100

ENROLLING GROUP NUMBER: 903022

EFFECTIVE DATE: January 1, 2015

Offered and Underwritten by
UnitedHealthcare Insurance Company

UnitedHealthcare Insurance Company

Dental Certificate of Coverage

This *Certificate of Coverage* ("*Certificate*") sets forth your rights and obligations as a Covered Person. It is important that you READ YOUR CERTIFICATE CAREFULLY and familiarize yourself with its terms and conditions.

The Policy may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost a Subscriber must pay can be obtained from the Enrolling Group.

UnitedHealthcare Insurance Company ("Company") agrees with the Enrolling Group to provide Coverage for Dental Services to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. The Policy is issued on the basis of the Enrolling Group's application and payment of the required Policy Charges. The Enrolling Group's application is made a part of the Policy.

The Company will not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. The Company will not be responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's benefit plan.

The Policy will take effect on the date specified in the Policy and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of the Policy as provided. All Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight at the Enrolling Group's address.

The Policy is delivered in and governed by the laws of the State of Louisiana.

Introduction to Your Certificate

You and any of your Enrolled Dependents, are eligible for Coverage under the Policy if the required Premiums have been paid. The Policy is referred to in this *Certificate* as the "Policy" and is designated on the identification ("ID") card.

Coverage is subject to the terms, conditions, exclusions, and limitations of the Policy. As a *Certificate*, this document describes the provisions of Coverage under the Policy but does not constitute the Policy. You may examine the entire Policy at the office of the Enrolling Group during regular business hours.

For Dental Services rendered after the effective date of the Policy, this *Certificate* replaces and supersedes any *Certificate*, which may have been previously issued to you by the Company. Any subsequent *Certificates* issued to you by the Company will in turn supersede this *Certificate*.

The employer expects to continue the group plan indefinitely. But the employer reserves the right to change or end it at any time. This would change or end the terms of the Policy in effect at that time for active or retired employees.

How To Use This Certificate

This *Certificate* should be read and re-read in its entirety. Many of the provisions of this *Certificate* and the attached *Schedule of Covered Dental Services* are interrelated; therefore, reading just one or two provisions may not give you an accurate impression of your Coverage.

Your *Certificate* and *Schedule of Covered Dental Services* may be modified by the attachment of Riders and/or Amendments. Please read the provision described in these documents to determine the way in which provisions in this *Certificate* or *Schedule of Covered Dental Services* may have been changed.

Many words used in this *Certificate* and *Schedule of Covered Dental Services* have special meanings. These words will appear capitalized and are defined for you in *Section 1: Definitions*. By reviewing these definitions, you will have a clearer understanding of your *Certificate* and *Schedule of Covered Dental Services*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in *Section 1: Definitions*.

From time to time, the Policy may be amended. When that happens, a new *Certificate*, *Schedule of Covered Dental Services* or Amendment pages for this *Certificate* or *Schedule of Covered Dental Services* will be sent to you. Your *Certificate* and *Schedule of Covered Dental Services* should be kept in a safe place for your future reference.

Network and Non-Network Benefits

This *Certificate* describes both benefit levels available under the Policy.

Network Benefits - These benefits apply when you choose to obtain Dental Services from a Network Dentist. *Section 10: Procedures for Obtaining Benefits* describes the procedures for obtaining Covered Dental Services as Network Benefits. Unless otherwise noted in the *Schedule of Covered Dental Services* or *Section 11: Covered Dental Services*, Network Benefits generally require you to pay less to the provider than Non-Network Benefits. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dentist an amount for a Covered Dental Service in excess of the contracted fee.

Non-Network Benefits - These benefits apply when you decide to obtain Dental Services from Non-Network Dentists. *Section 10: Procedures for Obtaining Benefits* describes the procedures for obtaining Covered Dental Services as Non-Network Benefits. Unless otherwise noted in the *Schedule of Covered Dental Services* or *Section 11: Covered Dental Services*, Non-Network Benefits generally require you to pay more than Network Benefits. Non-Network Benefits are determined based on the contracted fee for similarly situated Network Dentists for each Covered Dental Service. The actual charge made by a Non-

Network Dentist for a Covered Dental Service may exceed the contracted fee. As a result, you may be required to pay a Non-Network Dentist an amount for a Covered Dental Service in excess of the contracted fee. In addition, when you obtain Covered Dental Services from Non-Network Dentists, you must file a claim with the Company to be reimbursed for Eligible Expenses.

The information in *Section 1: Definitions* through *Section 9: Continuation of Coverage* applies to both levels of Coverage. *Section 10: Procedures for Obtaining Benefits*, the *Schedule of Covered Dental Services* and *Section 11: Covered Dental Services* explain the procedures you must follow to obtain Coverage for Network Benefits and Non-Network Benefits. The *Schedule of Covered Dental Services* or *Section 11: Covered Dental Services* describe which Dental Services are Covered. Unless otherwise specified, the exclusions and limitations that appear in *Section 12: General Exclusions* apply to both levels of benefits. The *Schedule of Covered Dental Services* or *Section 11: Covered Dental Services* describe what Copayments are required, if any, and to what extent any limitations apply.

Dental Services Covered Under the Policy

In order for Dental Services to be Covered as Network Benefits, you must obtain all Dental Services directly from or through a Network Dentist.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling the Company and/or provider. If necessary, the Company can provide assistance in referring you to Network Dentists. If you use a provider that is not a participating provider, you will be required to pay the entire bill for the services you received.

Only Necessary Dental Services are Covered under the Policy. The fact that a Dentist has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is Covered under the Policy.

The Company has sole and exclusive discretion in interpreting the benefits Covered under the Policy and the other terms, conditions, limitations and exclusions set out in the Policy and in making factual determinations related to the Policy and its benefits. The Company may, from time to time, delegate discretionary authority to other persons or entities providing services in regard to the Policy.

The Company reserves the right to change, interpret, modify, withdraw or add benefits or terminate the Policy, in its sole discretion, as permitted by law, without the approval of Covered Persons. No person or entity has any authority to make any oral changes or amendments to the Policy.

The Company may, in certain circumstances for purposes of overall cost savings or efficiency and in its sole discretion, provide Coverage for services, which would otherwise not be Covered. The fact that the Company does so in any particular case will not in any way be deemed to require it to do so in other similar cases.

The Company may, in its sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, including claims processing and utilization management services. The identity of the service providers and the nature of the services provided may be changed from time to time in the Company's sole discretion and without prior notice to or approval by Covered Persons. You must cooperate with those persons or entities in the performance of their responsibilities.

Similarly, the Company may, from time to time, require additional information from you to verify your eligibility or your right to receive Coverage for services under the Policy. You are obligated to provide this information. Failure to provide required information may result in Coverage being delayed or denied.

Important Note About Services

The Company does not provide Dental Services or practice dentistry. Rather, the Company arranges for providers of Dental Services to participate in a Network. Network Dentists are independent practitioners and are not employees of the Company. The Company, therefore, makes payment to Network Dentists through various types of contractual arrangements. These arrangements may include financial incentives

to promote the delivery of dental care in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to Necessary Dental Services.

The payment methods used to pay any specific Network Dentist vary. The method may also change at the time providers renew their contracts with the Company. If you have questions about whether there are any financial incentives in your Network Dentist's contract with the Company, please contact the Company at the telephone number on your ID card. The Company can advise you whether your Network Dentist is paid by any financial incentive, however, the specific terms, including rates of payment, are confidential and cannot be disclosed.

The Dentist-patient relationship is between you and your Dentist. This means that:

- You are responsible for choosing your own Dentist.
- You must decide if any Dentist treating you is right for you. This includes Network Dentists who you choose or providers to whom you have been referred.
- You must decide with your Dentist what care you should receive.
- Your Dentist is solely responsible for the quality of the care you receive.

The Company makes decisions about eligibility and if a benefit is a Covered benefit under the Policy. These decisions are administrative decisions. The Company is not liable for any act or omission of a provider of Dental Services.

Important Information Regarding Medicare

Coverage under the Policy is not intended to supplement any coverage provided by Medicare, but in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled for Coverage under the Policy. If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare, you must enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll, and if the Company is the secondary payer as described in *Section 7: Coordination of Benefits* of this *Certificate*, the Company will pay benefits under the Policy as if you were covered under both Medicare Part A and Part B and you will incur a larger out of pocket cost for Health Services.

If, in addition to being enrolled for Coverage under the Policy, you are enrolled in a *Medicare Advantage* (Medicare Part C) plan, you must follow all rules of that plan that require you to seek services from that plan's participating providers. When the Company is the secondary payer, we will pay any benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. If the Company is the secondary plan and you don't follow the rules of the *Medicare Advantage* plan, you will incur a larger out of pocket cost for Dental Services.

If, in addition to being enrolled for Coverage under the Policy, you are enrolled in a Medicare Prescription Drug (Medicare Part D) plan through either a *Medicare Advantage* plan with a prescription drug benefit (MA-PD), a special-needs plan (SNP-PD) or a stand alone Prescription Drug Plan (PDP), you must follow all rules of that plan that require you to seek services from that plan's participating pharmacies. When this Company is the secondary payer, we will pay any benefits available to you under the Policy as if you had followed all rules of the Medicare Part D plan. If this Company is the secondary plan and you don't follow the rules of the Medicare Part D plan, you will incur a larger out of pocket cost for prescription drugs.

Identification ("ID") Card

You must show your ID card every time you request Dental Services. If you do not show your card, the providers have no way of knowing that you are Covered under a Policy issued by the Company and you may receive a bill for Network Benefits.

Contact the Company

Throughout this *Certificate* you will find statements that encourage you to contact the Company for further information. Whenever you have a question or concern regarding Dental Services or any required procedure, please contact the Company at the telephone number stated on your ID card.

Dental Certificate of Coverage Table of Contents

Section 1: Definitions.....	7
Section 2: Enrollment and Effective Date of Coverage	11
Section 3: Termination of Coverage.....	13
Section 4: Reimbursement	15
Section 5: Complaint Procedures.....	17
Section 6: General Provisions	19
Section 7: Coordination of Benefits.....	22
Section 8: Subrogation and Refund of Expenses	26
Section 9: Continuation of Coverage	28
Section 10: Procedures for Obtaining Benefits.....	31
Section 11: Covered Dental Services.....	33
Section 12: General Exclusions	35

Section 1: Definitions

This Section defines the terms used throughout this *Certificate* and *Schedule of Covered Dental Services* and is not intended to describe Covered or uncovered services.

Amendment - any attached description of additional or alternative provisions to the Policy. Amendments are effective only when signed by an officer of the Company. Amendments are subject to all conditions, limitations and exclusions of the Policy except for those which are specifically amended.

Congenital Anomaly - a physical developmental defect that is present at birth and identified within the first twelve months from birth.

Copayment - the charge you are required to pay for certain Dental Services payable under the Policy. A Copayment may either be a defined dollar amount or a percentage of Eligible Expenses. You are responsible for the payment of any Copayment for Network Benefits directly to the provider of the Dental Service at the time of service or when billed by the provider.

Coverage or Covered - the entitlement by a Covered Person to reimbursement for expenses incurred for Dental Services covered under the Policy, subject to the terms, conditions, limitations and exclusions of the Policy. Dental Services must be provided: (1.) when the Policy is in effect; and (2.) prior to the date that any of the individual termination conditions as stated in *Section 3: Termination of Coverage* occur; and (3.) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Policy.

Covered Person – either the Subscriber or an Enrolled Dependent, while Coverage of such person under the Policy is in effect. References to you and your throughout this *Certificate* are references to a Covered Person.

Deductible – the amount a Covered Person must pay for Dental Services in a calendar year before the Company will begin paying for Benefits in that calendar year. Any amount the Covered Person pays for Dental Services in the last 3 months of the previous calendar year which are applied to the previous Deductible will be carried over and applied to the current Deductible. This carry over feature applies only to the individual Deductible.

Dental Service or Dental Procedures - dental care or treatment provided by a Dentist to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by the Company as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dentist - any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dependent - (1.) the Subscriber's legal spouse. or (2.) a dependent child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, a legally adopted child, a child placed for adoption, or a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse). Any unmarried child who is placed in the home of an insured pursuant to an adoption placement agreement executed with a licensed adoption agency shall be considered a dependent child of the insured from the date of placement in the home of the insured. The term child also includes a grandchild who is in the legal custody of either the Subscriber or the Subscriber's spouse. Any unmarried child who is placed in the home of an insured following execution of an act of voluntary surrender in favor of the insured or the insured's legal representative shall be considered a dependent child of the insured effective on the date on which the act of voluntary surrender becomes irrevocable. To be eligible for coverage under the Policy, a Dependent must reside within the United States. The definition of Dependent is subject to the following conditions and limitations:

- A. The term Dependent will not include any dependent child 26 years of age or older, except as stated in *Section 3: Termination of Coverage, sub-section 3.2: Extended Coverage for Handicapped Children*.

The Subscriber agrees to reimburse the Company for any Dental Services provided to the child at a time when the child did not satisfy these conditions.

The term Dependent also includes a child for whom dental care coverage is required through a Qualified Medical Child Support Order or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

The term Dependent does not include anyone who is also enrolled as a Subscriber, nor can anyone be a Dependent of more than one Subscriber.

Eligible Expenses – Eligible Expenses for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- A. For Network Benefits, when Covered Dental Services are received from Network Dentists, Eligible Expenses are the Company's contracted fee(s) for Covered Dental Services with that provider.
- B. For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dentists, Eligible Expenses are the Company's contracted fee(s) for Covered Dental Services with a Network Dentist in the same geographic area.

In the event that a provider routinely waives Copayments and/or the Deductible for Non-Network benefits, Dental Services for which the Copayments and/or the Deductible are waived are not considered to be Eligible Expenses.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy.

Emergency - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Enrolled Dependent - a Dependent who is properly enrolled for Coverage under the Policy.

Enrolling Group - the employer or other defined or otherwise legally constituted group to whom the Policy is issued.

Experimental, Investigational or Unproven Services - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, is determined to be:

- A. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- B. Subject to review and approval by any institutional review board for the proposed use; or
- C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- D. Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Foreign Services - are defined as services provided outside the U.S. and U.S. territories.

Initial Eligibility Period - the initial period of time, determined by the Company and the Enrolling Group, during which Eligible Persons may enroll themselves and Dependents under the Policy.

Maximum Benefit – the maximum amount paid for Covered Dental Services during a calendar year for a Covered Person under the Policy or any Policy, issued by the Company to the Enrolling Group, that replaces the Policy. The Maximum Benefit is stated in *Section 11: Covered Dental Services*.

Medicare – Parts A, B, C, and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Necessary - Dental Services and supplies which are determined by the Company through case-by-case assessments of care based on accepted dental practices to be appropriate; and

- A. necessary to meet the basic dental needs of the Covered Person; and
- B. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service; and
- C. consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; and
- D. consistent with the diagnosis of the condition; and
- E. required for reasons other than the convenience of the Covered Person or his or her Dentist; and
- F. demonstrated through prevailing peer-reviewed dental literature to be either:
 - 1. safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
 - 2. safe with promising efficacy
 - a. for treating a life threatening dental disease or condition; and
 - b. in a clinically controlled research setting; and
 - c. using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this *Certificate*. The definition of Necessary used in this *Certificate* relates only to Coverage and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

Network - a group of Dentists who are subject to a participation agreement in effect with the Company, directly or through another entity, to provide Dental Services to Covered Persons. The participation status of providers will change from time to time.

Network Benefits - benefits available for Covered Dental Services when provided by a Dentist who is a Network Dentist.

Non-Network Benefits - coverage available for Dental Services obtained from Non-Network Dentists.

Open Enrollment Period - after the Initial Eligibility Period, a period of time determined by the Company and the Enrolling Group, during which Eligible Persons may enroll themselves and Dependents under the Policy.

Physician - any Doctor of Medicine, M.D., or Doctor of Osteopathy, D.O., who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

Plan Allowance - is shown as a fixed dollar amount or percentage of Eligible Expenses after the Deductible is satisfied and is the maximum benefit amount the Company will pay for each particular Dental Procedure shown. The Subscriber must pay the amount of the Dentist's fee, if any, which is greater than the amount of the Plan Allowance.

Policy - the group Policy, the application of the Enrolling Group, Amendments and Riders which constitute the agreement regarding the benefits, exclusions and other conditions between the Company and the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents Covered under the Policy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent in accordance with the terms of the Policy.

Procedure in Progress - all treatment for Covered Dental Services that results from a recommendation and an exam by a Dentist. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

Rider - any attached description of Dental Services Covered under the Policy. Dental Services provided by a Rider may be subject to payment of additional Premiums and additional Copayments. Riders are effective only when signed by an officer of the Company and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended.

Subscriber - an Eligible Person who is properly enrolled for Coverage under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Section 2: Enrollment and Effective Date of Coverage

Section 2.1 Enrollment

Eligible Persons may enroll themselves and their Dependents for Coverage under the Policy during the Initial Eligibility Period or during an Open Enrollment Period by submitting a form provided or approved by the Company. In addition, new Eligible Persons and new Dependents may be enrolled as described below. Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for Coverage under the Policy.

If you enroll for Coverage under the Policy, you must remain enrolled for a period of 12 months. If you disenroll at the end of any 12 month period, you must wait 12 months until you are again eligible for Coverage.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

Section 2.2 Effective Date of Coverage

In no event is there Coverage for Dental Services rendered or delivered before the effective date of Coverage.

If an Eligible Person enrolls during the Initial Eligibility Period, Coverage is effective on the first day of the policy month following the month in which the probationary period was completed.

Section 2.3 Coverage for a Newly Eligible Person

Coverage for you and any of your Dependents will take effect on the date agreed to by the Enrolling Group and the Company. Coverage is effective only if the Company receives any required Premium and a properly completed enrollment form within 31 days of the date you first become eligible.

Section 2.4 Coverage for a Newly Eligible Dependent

Coverage for a new Dependent acquired by reason of birth, legal adoption, legal guardianship, placement for adoption, court or administrative order, or marriage will take effect on the date of the event. Coverage is effective only if the Company receives any required Premium and is notified of the event within 31 days.

Section 2.5 Change in Family Status

You may make Coverage changes during the year for any Dependent whose status as a Dependent is affected by a marriage, divorce, legal separation, annulment, birth, legal guardianship, placement for adoption or adoption, as required by federal law. In such cases you must submit the required contribution of coverage and a properly completed enrollment form within 31 days of the marriage, birth, placement for adoption or adoption. Otherwise, you will need to wait until the next annual Open Enrollment Period.

Section 2.6 Special Enrollment Period

An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period or Open Enrollment Period may enroll for Coverage during a special enrollment period. A special enrollment period is available if the following conditions are met: (a.) the Eligible Person and/or Dependent had existing health coverage under another plan at the time of the Initial Eligibility Period or Open Enrollment Period; and (b.) Coverage under the prior plan was terminated as a result of loss of eligibility (including, without limitation, legal separation, divorce or death), termination of employer contributions, or in the case of COBRA continuation coverage, the coverage was exhausted. A special enrollment period is not available if coverage under the prior plan was terminated for cause or as a result of failure to pay Premiums on a timely basis. Coverage under the Policy is effective only if the Company

receives any required Premium and a properly completed enrollment form within 31 days of the date coverage under the prior plan terminated. A special enrollment period is also available for an Eligible Person and for any Dependent whose status as a Dependent is affected by a marriage, birth, placement for adoption or adoption, as required by federal law. In such cases you must submit the required Premium and a properly completed enrollment form within 31 days of the marriage, birth, placement for adoption or adoption.

Section 3: Termination of Coverage

Section 3.1 Conditions for Termination of a Covered Person's Coverage Under the Policy

The Company may, at any time, discontinue this benefit plan and/or all similar benefit plans for the reasons specified in the Policy. When your Coverage terminates, you may have continuation as described in *Section 9: Continuation of Coverage* or as provided under other applicable federal and/or state law.

Your Coverage, including coverage for Dental Services rendered after the date of termination for dental conditions arising prior to the date of termination, will automatically terminate on the earliest of the dates specified below.

- A. The date the entire Policy is terminated, as specified in the Policy. The Enrolling Group is responsible for notifying you of the termination of the Policy.

The Company will not cancel or refuse to renew any policy of group or family group health and accident insurance except for nonpayment of premium or failure to meet the requirements for being a group or family group insurance policy until 60 days after the insurer has mailed written notice of such cancellation or nonrenewal by certified mail to the policyholder. The notice will include the reason the policy is being cancelled.
- B. The last day of the calendar month in which you cease to be eligible as a Subscriber or Enrolled Dependent.
- C. The date the Company receives written notice from either the Subscriber or the Enrolling Group instructing the Company to terminate Coverage of the Subscriber or any Covered Person or the date requested in such notice, if later.
- D. The date the Subscriber is retired or pensioned under the Enrolling Group's Plan, unless a specific Coverage classification is specified for retired or pensioned persons in the Enrolling Group's application and the Subscriber continues to meet any applicable eligibility requirements.

When any of the following apply, the Company will provide written notice of termination to the Subscriber.

- E. The date specified by the Company that all Coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided the Company with false material information, including, but not limited to, false, material information relating to residence, information relating to another person's eligibility for Coverage or status as a Dependent. The Company has the right to rescind Coverage back to the effective date.
- F. The date specified by the Company that all Coverage will terminate because the Subscriber permitted the use of his or her ID card by any unauthorized person or used another person's card.
- G. The date specified by the Company that Coverage will terminate due to material violation of the terms of the Policy.
- H. The date specified by the Company that your Coverage will terminate because you failed to pay a required Copayment.
- I. The date specified by the Company that your Coverage will terminate because you have committed acts of physical or verbal abuse which pose a threat to the Company staff, a provider, or other Covered Persons.

The Company will only be liable for services rendered subsequent to the cancellation date if such claim is for an illness or condition which was the basis of any prior claim.

Section 3.2 Extended Coverage for Handicapped Dependent Children

Coverage of an unmarried Enrolled Dependent who is incapable of self-support because of mental retardation or physical handicap will be continued beyond the age listed under the definition of Dependent provided that:

- A. the Enrolled Dependent becomes incapacitated prior to attainment of the limiting age; and
- B. the Enrolled Dependent is chiefly dependent upon the Subscriber for support and maintenance; and
- C. proof of such incapacity and dependence is furnished to the Company within 31 days of the date the Subscriber receives a request for such proof from the Company; and
- D. payment of any required Premium for the Enrolled Dependent is continued.

Coverage will be continued so long as the Enrolled Dependent continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Policy. Before granting this extension, the Company may reasonably require that the Enrolled Dependent be examined at the Company's expense by a Physician designated by the Company. At reasonable intervals, the Company may require satisfactory proof of the Enrolled Dependent's continued incapacity and dependency, including medical examinations at the Company's expense. Such proof will not be required more often than once a year. Failure to provide such satisfactory proof within 31 days of the request by the Company will result in the termination of the Enrolled Dependent's Coverage under the Policy.

Section 3.3 Extended Coverage

A 30 day temporary extension of Coverage, only for the services shown below when given in connection with a Procedure in Progress, will be granted to a Covered Person on the date the person's Coverage is terminated if termination is not voluntary. Benefits will be extended until the earlier of: (a.) the end of the 30 day period; or (b.) the date the Covered Person becomes covered under a succeeding policy or contract providing coverage or services for similar dental procedures.

Benefits will be Covered for: (a.) a Procedure in Progress or Dental Procedure that was recommended in writing and began, in connection with a specific dental disease of a Covered Person while the Policy was in effect, by the attending Dentist; (b.) an appliance, or modification to an appliance, for which the impression was taken prior to the termination of Coverage; or (c.) a crown, bridge or gold restoration, for which the tooth was prepared prior to the termination of Coverage.

Section 3.4 Payment and Reimbursement Upon Termination

Termination of Coverage will not affect any request for reimbursement of Eligible Expenses for Dental Services rendered prior to the effective date of termination. Your request for reimbursement must be furnished as required in *Section 4: Reimbursement*.

Section 4: Reimbursement

Section 4.1 Reimbursement of Eligible Expenses

The Company will reimburse you for Eligible Expenses subject to the terms; conditions, exclusions and limitations of the Policy and as described below.

Section 4.2 Filing Claims for Reimbursement of Eligible Expenses

You are responsible for sending a request for reimbursement to the Company's office, on a form provided by or satisfactory to the Company. Requests for reimbursement should be submitted within 90 days after date of service. Unless you are legally incapacitated, failure to provide this information to the Company within 1 year of the date of service will cancel or reduce Coverage for the Dental Service.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Your name and address
- Patient's name and age
- Number stated on your ID card
- The name and address of the provider of the service(s)
- A diagnosis from the Dentist including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim
- Radiographs, lab or hospital reports
- Casts, molds or study models
- Itemized bill which includes the CPT or ADA codes or description of each charge
- The date the dental disease began
- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call the Company at the telephone number stated on your ID Card and a claim form will be sent to you. If you do not receive the claim form within 15 days of your request, send in the proof of loss with the information stated above.

Proof of Loss. Written proof of loss should be given to the Company within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service.

Payment of Claims. Benefits are payable in accordance with any state prompt pay requirements after the Company receives acceptable proof of loss. Benefits will be paid to you unless:

- A. The provider notifies the Company that your signature is on file assigning benefits directly to that provider; or
- B. You make a written request at the time the claim is submitted.

All claims shall be paid not more than thirty days from the date upon which written notice and proof of claim, in the form required by the terms of the policy, are furnished to the Company unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. Failure to comply with the provisions of this Section shall subject the Company to a penalty payable to the insured of double the amount of the health and accident benefits due under the terms of the policy or contract during the period of delay, together with attorney's fees to be determined by the court.

Subject to written authorization from a Subscriber, all or a portion of any Eligible Expenses due may be paid directly to the provider of the Dental Services instead of being paid to the Subscriber.

Section 4.3 Limitation of Action for Reimbursement

You do not have the right to bring any legal proceeding or action against the Company to recover reimbursement until 90 days after you have properly submitted a request for reimbursement, as described above. If you do not bring such legal proceeding or action against the Company within 3 years from the date satisfactory written proof of loss was submitted to us, you forfeit your rights to bring any action against the Company.

Section 5: Complaint Procedures

Section 5.1 Complaint Resolution

If you have a concern or question regarding the provision of Dental Services or benefits under the Policy, you should contact the Company's customer service department 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. At other times, you may leave a message on voicemail. A customer service representative will return your call. If you would rather send your concern to us in writing at this point, the Company's authorized representative can provide you with the appropriate address.

If the customer service representative cannot resolve the issue to your satisfaction over the phone, he or she can provide you with the appropriate address to submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

If you disagree with our decision after having submitted a written complaint, you can ask us in writing to formally reconsider your complaint. If your complaint relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card
- The date(s) of service(s)
- The provider's name
- The reason you believe the claim should be paid
- Any new information to support your request for claim payment

We will notify you of our decision regarding our reconsideration of your complaint within 60 days of receiving it. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Section 5.2 Complaint Hearing

If you request a hearing, we will appoint a committee to resolve or recommend the resolution of your complaint. If your complaint is related to clinical matters, the Company may consult with, or seek the participation of, medical and/or dental experts as part of the complaint resolution process.

The committee will advise you of the date and place of your complaint hearing. The hearing will be held within 60 days following receipt of your request by the Company, at which time the committee will review testimony, explanation or other information that it decides is necessary for a fair review of the complaint.

We will send you written notification of the committee's decision within 30 days of the conclusion of the hearing. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Section 5.3 Exceptions for Emergency Situations

Your complaint requires immediate actions when your Dentist judges that a delay in treatment would significantly increase the risk to your health. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Dentist should call us as soon as possible.
- We will notify you of the decision by the end of the next business day after your complaint is received, unless more information is needed.
- If we need more information from your Dentist to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The complaint process for urgent situations does not apply to prescheduled treatments or procedures that we do not consider urgent situations.

If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Section 6: General Provisions

Section 6.1 Entire Policy

The Policy issued to the Enrolling Group, including the *Certificate(s)*, *Schedule(s) of Covered Dental Services*, the Enrolling Group's application, Amendments and Riders, constitute the entire Policy. All statements made by the Enrolling Group or by a Subscriber will, in the absence of fraud, be deemed representations and not warranties.

Section 6.2 Limitation of Action

You do not have the right to bring any legal proceeding or action against the Company without first completing the complaint procedure specified in *Section 5: Complaint Procedures*. If you do not bring such legal proceeding or action against the Company within 3 years of the date the Company notified you of its final decision as described in *Section 5: Complaint Procedures*; you forfeit your rights to bring any action against the Company.

The only exception to this limitation of action is that reimbursement of Eligible Expenses, as set forth in *Section 4: Reimbursement*, is subject to the limitation of action provision of that Section.

Section 6.3 Time Limit on Certain Defenses

No statement, except a fraudulent statement, made by the Enrolling Group will be used to void the Policy after it has been in force for a period of 2 years.

Section 6.4 Amendments and Alterations

Amendments to the Policy are effective upon 31 days written notice to the Enrolling Group. Riders are effective on the date specified by the Company. No change will be made to the Policy unless it is made by an Amendment or a Rider that is signed by an officer of the Company. No agent has authority to change the Policy or to waive any of its provisions.

Section 6.5 Relationship Between Parties

The relationships between the Company and Network providers and relationships between the Company and Enrolling Groups, are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of Network providers or Enrolling Groups.

The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided to any Covered Person.

The relationship between the Enrolling Group and Covered Persons is that of employer and employee, Dependent or other Coverage classification as defined in the Policy. The Enrolling Group is solely responsible for enrollment and Coverage classification changes (including termination of a Covered Person's Coverage through the Company), for the timely payment of the Policy Charge to the Company, and for notifying Covered Persons of the termination of the Policy.

Section 6.6 Information and Records

At times the Company may need additional information from you. You agree to furnish the Company with all information and proofs that the Company may reasonably require regarding any matters pertaining to the Policy. If you do not provide this information when the Company requests it we may delay or deny payment of your Benefits.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish the Company with all information or copies of records relating to the services provided to you. The Company has the right to request this information at any reasonable time.

This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. The Company agrees that such information and records will be considered confidential.

The Company has the right to release any and all records concerning dental care services which are necessary to implement and administer the terms of the Policy, for appropriate review or quality assessment, or as the Company is required to do by law or regulation. During and after the term of the Policy, the Company and its related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your dental records or billing statements the Company recommends that you contact your Dentist. Dentists may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request dental forms or records from us, the Company also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, the Company will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. The Company's designees have the same rights to this information as the Company has.

Section 6.7 Examination of Covered Persons

In the event of a question or dispute concerning Coverage for Dental Services, the Company may reasonably require that a Network Dentist acceptable to the Company examine you at the Company's expense.

Section 6.8 Clerical Error

If a clerical error or other mistake occurs, that error will not deprive you of Coverage under the Policy. A clerical error also does not create a right to benefits.

Section 6.9 Notice

When the Company provides written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons.

Section 6.10 Workers' Compensation Not Affected

The Coverage provided under the Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

Section 6.11 Conformity with Statutes

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Section 6.12 Waiver/Estoppel

Nothing in the Policy, *Certificate* or *Schedule of Covered Dental Services* is considered to be waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of the Policy, *Certificate* or *Schedule of Covered Dental Services*, or to exercise any option which is herein provided, shall in no way be construed to be a waiver of such provision of the Policy, *Certificate* or *Schedule of Covered Dental Services*.

Section 6.13 Headings

The headings, titles and any table of contents contained in the Policy, *Certificate* or *Schedule of Covered Dental Services* are for reference purposes only and shall not in any way affect the meaning or interpretation of the Policy, *Certificate* or *Schedule of Covered Dental Services*.

Section 6.14 Unenforceable Provisions

If any provision of the Policy, *Certificate* or *Schedule of Covered Dental Services* is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Policy, *Certificate* or *Schedule of Covered Dental Services* to the greatest extent legally permissible.

Section 7: Coordination of Benefits

Section 7.1 Coordination of Benefits Applicability

This coordination of benefits (COB) provision applies when a person has health or dental coverage under more than one Coverage Plan. "Coverage Plan" is defined below.

The order of benefit determination rules below determine which Coverage Plan will pay as the primary Coverage Plan. The primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A secondary Coverage Plan pays after the primary Coverage Plan and may reduce the benefits it pays so that payments from all group Coverage Plans do not exceed 100% of the total allowable expense.

Section 7.2 Definitions

For purposes of this Section, Coordination of Benefits, terms are defined as follows:

- A. A "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
1. "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
 2. "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

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

- B. The order of benefit determination rules determine whether this Coverage Plan is a "primary Coverage Plan" or "secondary Coverage Plan" when compared to another Coverage Plan covering the person.

When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the primary Coverage Plan's benefits.

- C. "Allowable expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example a dental HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
1. If a person is covered by 2 or more Coverage Plans that compute their benefit payments on the basis of Usual and Customary fees, any amount in excess of the highest of the Usual and Customary fees for a specific benefit is not an allowable expense.
 2. If a person is covered by 2 or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

3. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of Usual and Customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the primary Coverage Plan's payment arrangements will be the allowable expense for all Coverage Plans.
- D. "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.
- E. "Closed panel Coverage Plan" is a Coverage Plan that provides health or dental benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Section 7.3 Order of Benefit Determination Rules

When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

- A. The primary Coverage Plan pays or provides its benefits as if the secondary Coverage Plan or Coverage Plans did not exist.
- B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage will be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.
- C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.
- D. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.
 1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, Subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, Subscriber or retiree is secondary and the other Coverage Plan is primary.
 2. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Coverage Plan is:
 - a. The primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
 - 1.) The parents are married;
 - 2.) The parents are not separated (whether or not they ever have been married); or

- 3.) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

- b. If the specific terms of a court decree state that one of the parents is responsible for the child's health or dental care expenses or health or dental care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or Coverage Plan years commencing after the Coverage Plan is given notice of the court decree.
- c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - 1.) The Coverage Plan of the custodial parent;
 - 2.) The Coverage Plan of the spouse of the custodial parent;
 - 3.) The Coverage Plan of the noncustodial parent; and then
 - 4.) The Coverage Plan of the spouse of the noncustodial parent.
3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D.(1.).
4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage 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. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, Subscriber or retiree longer is primary.
6. If the preceding rules do not determine the primary Coverage Plan, the allowable expenses will be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

Section 7.4 Effect on the Benefits of This Coverage Plan

- A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total allowable expenses.

When this Coverage Plan is the secondary carrier, this Coverage Plan will only pay up to the allowable amount but never more than what this Coverage Plan would have paid as primary.

- B. If a covered person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB will not apply between that Coverage Plan and other closed panel Coverage Plans.
- C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare Advantage (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare Prescription Drug (Medicare Part D) plan and receives non-covered prescription drugs because the person did not follow all rules of that plan. If the drug is a Part D drug covered by the Medicare Prescription Drug plan, Medicare benefits are determined as if the services were provided by a network pharmacy and covered under Medicare Part D.

Section 7.5 Right to Receive and Release Needed Information

Certain facts about health or dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this Coverage Plan and other Coverage Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Coverage Plan must give the Company any facts it needs to apply those rules and determine benefit payable. If you do not provide the Company the information it needs to apply these rules and determine the benefits payable, your claim for benefits will be denied.

Section 7.6 Payments Made

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

Section 7.7 Right of Recovery

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

Section 8: Subrogation and Refund of Expenses

The Company's legal right to subrogation and reimbursement apply to the Covered Person only if the Covered Person will be made whole or fully compensated prior to the Company's attempt to subrogate. Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. The Company will be subrogated to and will succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits provided by the Company to you from: (i.) third parties, including any person alleged to have caused you to suffer injuries or damages; (ii.) your employer; or (iii.) any person or entity obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties"). You agree to assign to the Company all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits provided by the Company, plus reasonable costs of collection.

After nine months from the date of an auto accident from which medical claims arise, we are allowed to seek subrogation of the outstanding balance of any medical claims remaining from the "MedPay" portion of an automobile liability policy covering the insured person.

This excludes Medicare Advantage and self-funded (ASO) plans.

An exception to the provisions is allowed if there is an agreement between the parties and when our subrogation process is in accordance with the Louisiana Department of Insurance's regulation governing coordination of benefits (COB).

You will cooperate with the Company in protecting the Company's legal rights to subrogation and reimbursement. You will do nothing to prejudice the Company's rights under this provision, either before or after the need for services or benefits under the Policy. The Company may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in your name. You will hold in trust any proceeds of settlement or judgment for the benefit of the Company under these subrogation provisions. You will not accept any settlement that does not fully compensate or reimburse the Company without the written approval of the Company. You agree to execute and deliver such documents (including a written confirmation of assignment, and consents to release dental records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as may be reasonably requested by the Company.

Refund of Overpayments. If the Company pays 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 the Company if:

- A. 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,
- B. All or some of the payment made by the Company exceeded the benefits under the Policy, or
- C. All or some of the payment was made in error.

The refund equals the amount the Company paid in excess of the amount it should have paid under the Policy.

If the refund is due from another person or organization, the Covered Person agrees to help the Company 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, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Enrolling Group. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Reimbursement of Benefits Paid. If the Company pays benefits for expenses incurred on account of a Covered Person, the Subscriber or any other person or organization that was paid must make a refund to

the Company if all or some of the expenses were recovered from or paid by a source other than the Policy as a result of claims against a third party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount the Company paid.

If the refund is due from another person or organization, the Covered Person agrees to help the Company 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, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Enrolling Group. The reduction will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Section 9: Continuation of Coverage

Section 9.1 Continuation Coverage

A Covered Person whose Coverage would otherwise end under the Policy may be entitled to elect continuation Coverage in accordance with federal law (under COBRA) and as outlined in *Sections 9.2 through 9.5* below.

Continuation Coverage under COBRA will be available only to Enrolling Groups which are subject to the provisions of COBRA. Covered Persons should contact the Enrolling Group's plan administrator to determine if he or she is entitled to continue Coverage under COBRA.

Continuation Coverage for Covered Persons who selected continuation coverage under a prior plan which was replaced by Coverage under the Policy will terminate as scheduled under the prior plan or in accordance with the terminating events set forth in *Section 9.5* below, whichever is earlier.

In no event will the Company be obligated to provide continuation Coverage to a Covered Person if the Enrolling Group or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the Covered Person in a timely manner of the right to elect continuation Coverage and notifying the Company in a timely manner of the Covered Person's election of continuation Coverage.

The Company is not the Enrolling Group's designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

A Covered Person whose Coverage would otherwise end under the Policy may be entitled to elect continuation Coverage in accordance with federal law, as outlined in *Sections 9.2 through 9.5* below.

Section 9.2 Continuation Coverage Under Federal Law

In order to be eligible for continuation coverage under federal law, the Covered Person must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the plan on the day before a Qualifying Event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed in adoption with a Subscriber during a period of continuation of coverage, or
- A Subscriber's former spouse.

Section 9.3 Qualifying Events for Continuation Coverage Under Federal Law

If a Qualified Beneficiary's Coverage will ordinarily terminate due to one of the following Qualifying Events, he or she is entitled to continue Coverage. The Qualified Beneficiary is entitled to elect to continue the same Coverage that he or she had at the time of the Qualifying Event.

- A. Termination of the Subscriber from employment with the Enrolling Group (for any reason other than gross misconduct) or reduction of hours; or
- B. Death of the Subscriber; or
- C. Divorce or legal separation of the Subscriber; or
- D. Loss of eligibility by an Enrolled Dependent who is a child; or
- E. Entitlement of the Subscriber to Medicare benefits; or
- F. The Enrolling Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents. This is also a qualifying

event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Section 9.4 Notification Requirements and Election Period for Continuation Coverage Under Federal Law

The Subscriber or Qualified Beneficiary must notify the Enrolling Group's designated plan administrator within 60 days of his or her divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Subscriber or Qualified Beneficiary fails to notify the designated plan administrator of these events within the 60 day period the Enrolling Group and its plan administrator are not obligated to provide continuation Coverage to the affected Qualified Beneficiary. A Subscriber who is continuing Coverage under Federal Law must notify the Enrolling Group's designated plan administrator within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the Qualifying Event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Enrolling Group's designated plan administrator.

A Qualified Beneficiary whose Coverage was terminated due to a qualifying event must pay the initial Premium due to the Enrolling Group's designated plan administrator on or before the 45th day after electing continuation.

Section 9.5 Terminating Events for Continuation Coverage Under Federal Law

Continuation under the Policy will end on the earliest of the following dates :

- A. Eighteen months from the date of a Qualifying Event for a Qualified Beneficiary whose Coverage would have otherwise ended due to termination of employment (for reasons other than gross misconduct) or a reduction in hours. A Qualified Beneficiary who is determined to be disabled at the time during the first 60 days of continuation Coverage may extend continuation Coverage to a maximum of 29 months from the date of the Qualifying Event described in *Section 9.3*. If the Qualified Beneficiary entitled to the additional 11 months of Coverage has non-disabled family members who are also entitled to continuation Coverage, those non-disabled family members are also entitled to the additional 11 months of continuation Coverage.

A Qualified Beneficiary who is determined to have been disabled within the first 60 days of continuation Coverage for Qualifying Event (A.) must provide notice of such disability within 60 days after the determination of the disability, and in no event later than the end of the first 18 months, in order to extend Coverage beyond 18 months. If such notice is provided, the Qualified Beneficiary's Coverage may be extended up to a maximum of 29 months from the date of the Qualifying Event described in *Section 9.3*. A or until the first month that begins more than 30 days after the date of any final determination that the Qualified Beneficiary is no longer disabled. Each Qualified Beneficiary must provide notice of any final determination that the Qualified Beneficiary is no longer disabled within 30 days of such determination.

- B. Thirty-six months from the date of the Qualifying Event for an Enrolled Dependent whose Coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, loss of eligibility by an Enrolled Dependent who is a child, in accordance with qualifying events (B.), (C.), or (D.) described in *Section 9.3*.
- C. For the Enrolled Dependents of a Subscriber who was entitled to Medicare prior to a Qualifying Event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the Qualifying Event, or if later, 36 months from the date of the Subscriber's Medicare entitlement.
- D. The date Coverage terminates under the Policy for failure to make timely payment of the Premium.

- E. The date, after electing continuation Coverage, that coverage is obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition of the Qualified Beneficiary, continuation will end on the date such limitation or exclusion ends. The other group health coverage will be primary for all health services except those health services that are subject to the preexisting condition limitation or exclusion.
- F. The date, after electing continuation Coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this will not apply in the event the Qualified Beneficiary's Coverage was terminated because the Enrolling Group filed for bankruptcy, in accordance with qualifying event (F.) described in *Section 9.3*.
- G. The date the entire Policy ends.
- H. The date Coverage would otherwise terminate under the Policy.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second Qualifying Event occurs during that time, the continuation Coverage of a Qualified Beneficiary who is an Enrolled Dependent may be extended up to a maximum of 36 months from the Qualifying Event described in *Section 9.3 A*. If a Qualified Beneficiary is entitled to continuation because the Enrolling Group filed for bankruptcy, in accordance with Qualifying Event (F.) described in *Section 9.3* and the retired Subscriber dies during the continuation period, the Enrolled Dependents will be entitled to continue Coverage for 36 months from the date of death. Terminating events (B.) through (G.) described in this *Section 9.5* will apply during the extended continuation period.

Continuation Coverage for Qualified Beneficiaries whose continuation Coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Enrolling Group's designated plan administrator for information regarding the continuation period.

Section 10: Procedures for Obtaining Benefits

Section 10.1 Dental Services

You are eligible for Coverage for Dental Services listed in the *Schedule of Covered Dental Services* and *Section 11: Covered Dental Services* of this *Certificate* if such Dental Services are Necessary and are provided by or under the direction of a Dentist or other provider. All Coverage is subject to the terms, conditions, exclusions and limitations of the Policy.

Network Benefits

Dental Services must be provided by a Network Dentist in order to be considered Network Benefits.

When Dental Services are received from a Non-Network Provider as a result of an Emergency, the Copayment or Plan Allowance will be the Network Copayment or Plan Allowance.

Enrolling for Coverage under the Policy does not guarantee Dental Services by a particular Network Dentist on the list of providers. The list of Network Dentists is subject to change. When a provider on the list no longer has a contract with the Company, you must choose among remaining Network Dentists. You are responsible for verifying the participation status of the Dentist, or other provider prior to receiving such Dental Services. You must show your ID card every time you request Dental Services.

If you fail to verify participation status or to show your ID card, and the failure results in non-compliance with required Company procedures, Coverage of Network Benefits may be denied.

Coverage for Dental Services is subject to payment of the Premium required for Coverage under the Policy, satisfaction of any Deductible, appropriate Waiting Period, payment of the Copayment specified for any service and payment of the percentage of Eligible Expenses shown in the *Schedule of Covered Dental Services* and *Section 11: Covered Dental Services*.

Non-Network Benefits

Non-Network Benefits apply when you obtain Dental Services from Non-Network Dentists.

Before you are eligible for Coverage of Dental Services obtained from Non-Network Dentists, you must meet the requirements for payment of any Deductible and appropriate Waiting Period specified in the *Schedule of Covered Dental Services* and *Section 11: Covered Dental Services*. Non-Network Dentists may request that you pay all charges when services are rendered. You must file a claim with the Company for reimbursement of Eligible Expenses.

The Company reimburses a Non-Network Dentist for a covered Dental Service up to an amount equal to the contracted fee for the same covered Dental Service received from a similarly situated Network Dentist.

Network Dentists

The Company has arranged with certain dental care providers to participate in a Network. These Network Dentists have agreed to discount their charges for Covered services and supplies.

If Network Dentists are used, the amount of Covered expenses for which a Covered Person is responsible will generally be less than the amount owed if Non-Network Dentists had been used. The Copayment level (the percentage of Covered expenses for which a Covered Person is responsible) remains the same whether or not Network Dentists are used. However, because the total charges for Covered expenses may be less when Network Dentists are used, the portion that the Covered Person owes will generally be less.

Covered Persons are issued an identification card (ID card) showing they are eligible for Network discounts. A Covered Person must show this ID card every time Dental Services are given. This is how the provider knows that the patient is Covered under a Network plan. Otherwise, the person could be billed for the provider's normal charge.

A Directory of Network Dentists will be made available. A Covered Person can also call customer service to determine which providers participate in the Network. The telephone number for customer services is on the ID card.

Network Dentists are responsible for submitting a request for payment directly to the Company, however, a Covered Person is responsible for any Copayment at the time of service. If a Network Dentist bills a Covered Person, customer services should be called. A Covered Person does not need to submit claims for Network Dentist services or supplies.

Section 10.2 Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed \$500 or if a dental exam reveals the need for fixed bridgework, you may notify the Company of such treatment before treatment begins and receive a Pre-Treatment Estimate. If you desire a Pre-Treatment Estimate, you or your Dentist should send a notice to the Company, via claim form, within 20 days of the exam. If requested the Dentist must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company will determine if the proposed treatment is Covered under the Policy and estimate the amount of payment. The estimate of benefits payable will be sent to the Dentist and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

Pre-Treatment Estimate of benefits is not an agreement to pay for expenses. This procedure lets the Covered Person know in advance approximately what portion of the expenses will be considered for payment.

Section 11: Covered Dental Services

Dental Services described in this Section and in the *Schedule of Covered Dental Services* are Covered when such services are:

- A. Necessary;
- B. Provided by or under the direction of a Dentist;
- C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a benefit based on the least costly procedure; and
- D. Not excluded as described in Section 12: General Exclusions.

Covered Dental Services are subject to the satisfaction of any applicable Waiting Periods, Deductibles, Maximum Benefits, and payment of any Copayments as described below and in the Schedule of Covered Dental Services.

This Section and the *Schedule of Covered Dental Services*: (1) describe the Covered Dental Services and any applicable limitations to those services; (2) outline the Copayments that you are required to pay and any applicable Waiting Periods for each Covered Dental Service; and (3) describe any Deductible and any Maximum Benefits that may apply.

Network Benefits:

When Network Copayments are charged as a percentage of Eligible Expenses, the amount you pay for Dental Services from Network providers is determined as a percentage of the negotiated contract fee between the Company and the provider rather than a percentage of the provider's billed charge. The Company's negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge a Covered Person or the Company for any service or supply that is not Necessary as determined by the Company. If a Covered Person agrees to receive a service or supply that is not Necessary the Network provider may charge the Covered Person. However, these charges will not be considered Covered Dental Services and will not be payable by the Company.

Non-Network Benefits:

When Copayments are charged as a percentage of Eligible Expenses, the amount you pay for Dental Services from Non-Network providers is determined as a percentage of the negotiated contract rates of Network providers plus the amount by which the Non-Network provider's billed charge exceeds the contracted fee.

Deductible

Deductible is \$50 per Covered Person per calendar year and \$150 for all Covered Persons in a family.

The Deductible does not apply to: DIAGNOSTIC SERVICES and/or PREVENTIVE SERVICES.

The Deductible applies to any combination of the following Covered Dental Services: MINOR RESTORATIVE SERVICES, ENDODONTICS, PERIODONTICS, ORAL SURGERY, ADJUNCTIVE SERVICES, MAJOR RESTORATIVE SERVICES, FIXED PROSTHETICS, REMOVABLE PROSTHETICS.

Maximum Benefit

Maximum Benefit is \$1,500 per Covered Person per calendar year.

Maximum Benefit applies to any combination of the following Covered Dental Services: DIAGNOSTIC SERVICES, PREVENTIVE SERVICES, MINOR RESTORATIVE SERVICES, ENDODONTICS, PERIODONTICS, ORAL SURGERY, ADJUNCTIVE SERVICES, MAJOR RESTORATIVE SERVICES, FIXED PROSTHETICS, REMOVABLE PROSTHETICS.

Any required Copayment, Deductible, Waiting Period or Maximum Benefit is waived for a Covered Person in their 2nd or 3rd trimester of pregnancy for the following Covered Dental Services: prophylaxis, scaling and root planing, periodontal maintenance, full mouth debridement.

Section 11.1 CREDIT FOR PRIOR COVERAGE

If you are a Covered Person that becomes Covered under this Policy due to a mid-year plan change, you will need to submit evidence of having satisfied any portion of your prior policy's Deductible in order to receive credit under this Policy's applicable Deductible(s). You will also need to submit evidence of the total benefits paid under your prior policy in order to have the amount applied to this Policy's applicable Maximum(s).

Section 12: General Exclusions

Section 12.1 Exclusions

Except as may be specifically provided in the Schedule of Covered Dental Services or through a Rider to the Policy, the following are not Covered:

- A. Dental Services that are not Necessary.
- B. Hospitalization or other facility charges.
- C. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- D. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
- E. Any Dental Procedure not directly associated with dental disease.
- F. Any Dental Procedure not performed in a dental setting.
- G. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- H. Placement of dental implants, implant-supported abutments and prostheses.
- I. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- J. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- K. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- L. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
- M. Replacement of complete dentures, and fixed and removable partial dentures or crowns, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- N. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
- O. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
- P. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
- Q. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

- R. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- S. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- T. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
- U. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- V. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
- W. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
- X. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- Y. Orthodontic Services.
- Z. In the event that a Network or Non-Network Dentist routinely waives Copayments and/or the Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Deductible are waived is reduced by the amount waived by the Network or Non-Network provider.
- AA. Foreign Services are not Covered unless required as an Emergency.
- BB. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- CC. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.

SCHEDULE OF COVERED DENTAL SERVICES

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
DIAGNOSTIC SERVICES		
Bacteriologic Cultures	0%	0%
Viral Cultures	0%	0%
Intraoral Bitewing Radiographs Limited to once per 3 years.	0%	0%
Panorex Radiographs Limited to 1 time per consecutive 36 months.	0%	0%
Extraoral Radiographs Limited to 2 films per calendar year.	0%	0%
Intraoral - Complete Series (including bitewings) Limited to once per 3 years. Vertical bitewings cannot be billed in conjunction with a complete series.	0%	0%
Intraoral Periapical Radiographs	0%	0%
Intraoral Occlusal Film	0%	0%
Periodic Oral Evaluation Limited to 2 times per calendar year.	0%	0%
Comprehensive Oral Evaluation Limited to 2 times per calendar year. Not Covered if done in conjunction with other exams.	0%	0%
Limited or Detailed Oral Evaluation	0%	0%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Limited to 2 times per calendar year. Only 1 exam is Covered per date of service.		
Comprehensive Periodontal Evaluation - new or established patient Limited to 2 times per calendar year.	0%	0%
Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures Limited to 1 time per consecutive 12 months.	0%	0%
PREVENTIVE SERVICES		
Dental Prophylaxis Limited to either 2 prophylaxis and/or periodontal maintenance per calendar year.	0%	0%
Fluoride Treatments - child Limited to covered persons age of 18 and under, and limited once per calendar year.	0%	0%
Sealants Limited to once per 3 years.	0%	0%
Space Maintainers Limited to covered persons age 12 and under. Benefit includes all adjustments within 6 months of installation.	0%	0%
Re-Cement Space Maintainers	0%	0%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Limited to covered persons age 12 and under.		
Appliance Therapy, Fixed or Removable Limited to 1 time per consecutive 60 months. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances	0%	0%
MINOR RESTORATIVE SERVICES		
Amalgam Restorations Limited to 1 of any of these procedures per 6 months.	See fee schedule	See fee schedule
Composite Resin Restorations - Anterior Limited to 1 of any of these procedures per 6 months.	See fee schedule	See fee schedule
Gold Foil Restorations Multiple restorations on one surface will be treated as a single filling.	See fee schedule	See fee schedule
ENDODONTICS		
Apexification Limited to 1 time per tooth per lifetime.	See fee schedule	See fee schedule
Apicoectomy and Retrograde Filling Limited to 1 time per tooth per lifetime.	See fee schedule	See fee schedule
Hemisection Limited to 1 time per tooth per	See fee schedule	See fee schedule

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
lifetime.		
Root Canal Therapy Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	See fee schedule	See fee schedule
Retreatment of Previous Root Canal Therapy Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	See fee schedule	See fee schedule
Root Resection/Amputation Limited to 1 time per tooth per lifetime.	See fee schedule	See fee schedule
Therapeutic Pulpotomy Limited to 1 time per primary or secondary tooth per lifetime.	See fee schedule	See fee schedule
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration) Limited to 1 time per tooth per lifetime. Covered for anterior or posterior teeth only.	See fee schedule	See fee schedule
Pulpal Debridement, Primary and Permanent Teeth Limited to 1 time per tooth per lifetime. This procedure is not to be used when endodontic services are done on same date of service.	See fee schedule	See fee schedule

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
PERIODONTICS		
Crown Lengthening Limited to 1 quadrant or site per 2 years.	See fee schedule	See fee schedule
Gingivectomy/Gingivoplasty Limited to 1 per quadrant or site per consecutive 36 months.	See fee schedule	See fee schedule
Gingival Flap Procedure Limited to 1 per quadrant or site per consecutive 36 months.	See fee schedule	See fee schedule
Osseous Graft Limited to 1 per quadrant or site per consecutive 36 months.	See fee schedule	See fee schedule
Osseous Surgery Limited to 1 per quadrant or site per consecutive 36 months.	See fee schedule	See fee schedule
Guided Tissue Regeneration Limited to 1 per quadrant or site per consecutive 36 months.	See fee schedule	See fee schedule
Soft Tissue Surgery Limited to 1 per quadrant or site per consecutive 36 months.	See fee schedule	See fee schedule
Periodontal Maintenance Limited to either 2 prophylaxis and/or periodontal maintenance per calendar year.	See fee schedule	See fee schedule
Full Mouth Debridement Limited to once per calendar year.	See fee schedule	See fee schedule
Provisional Splinting	See fee schedule	See fee schedule

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
<p>Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges).</p> <p>Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.</p>		
<p>Scaling and Root Planing</p> <p>Limited to once per quadrant per calendar year.</p>	See fee schedule	See fee schedule
<p>Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report</p> <p>Limited to once per quadrant per calendar year.</p>	See fee schedule	See fee schedule
ORAL SURGERY		
Alveoloplasty	See fee schedule	See fee schedule
<p>Biopsy</p> <p>Limited to 1 biopsy per site per visit.</p>	See fee schedule	See fee schedule
Frenectomy/Frenuloplasty	See fee schedule	See fee schedule
<p>Removal of a Benign Cyst/Lesions</p> <p>Limited to 1 per site per visit.</p>	See fee schedule	See fee schedule
<p>Removal of Torus</p> <p>Limited to 1 per site per visit.</p>	See fee schedule	See fee schedule
<p>Root Removal, Surgical</p> <p>Limited to 1 time per tooth per</p>	See fee schedule	See fee schedule

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
lifetime.		
Simple Extractions Limited to 1 time per tooth per lifetime.	See fee schedule	See fee schedule
Surgical Extraction of Erupted Teeth or Roots Limited to 1 time per tooth per lifetime.	See fee schedule	See fee schedule
Surgical Extraction of Impacted Teeth Limited to 1 time per tooth per lifetime.	See fee schedule	See fee schedule
Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth Limited to 1 time per tooth per lifetime.	See fee schedule	See fee schedule
Primary Closure of a Sinus Perforation Limited to 1 per tooth per lifetime.	See fee schedule	See fee schedule
Placement of Device to Facilitate Eruption of Impacted Tooth Limited to 1 time per tooth per lifetime.	See fee schedule	See fee schedule
Vestibuloplasty Limited to 1 time per site per consecutive 60 months.	See fee schedule	See fee schedule
Excision of Hyperplastic Tissue Limited to 1 per site per consecutive 36 months.	See fee schedule	See fee schedule
Tooth Reimplantation and/or	See fee schedule	See fee schedule

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Transplantation Services Limited to 1 per site per lifetime.		
Oroantral Fistula Closure Limited to 1 per site per visit.	See fee schedule	See fee schedule
Excision of malignant lesion up to 1.25 cm Limited to once per tooth per lifetime	See fee schedule	See fee schedule
Excision of malignant lesion greater than 1.25 cm Limited to once per tooth per lifetime	See fee schedule	See fee schedule
Excision of malignant tumor-lesion diameter up to 1.25 cm Limited to once per tooth per lifetime	See fee schedule	See fee schedule
Excision of malignant tumor - lesion diameter greater than 1.25 cm Limited to once per tooth per lifetime	See fee schedule	See fee schedule
Excision of malignant lesion, complicated Limited to once per tooth per lifetime	See fee schedule	See fee schedule
Destruction of lesion(s) by physical or chemical method, by report Limited to once per tooth per lifetime	See fee schedule	See fee schedule
Removal of lateral exostosis (maxilla or mandible)	See fee schedule	See fee schedule

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Limited to once per tooth per lifetime		
Surgical reduction of osseous tuberosity Limited to once per tooth per lifetime	See fee schedule	See fee schedule
Radical resection of maxilla or mandible Limited to once per tooth per lifetime	See fee schedule	See fee schedule
Suture of recent small wounds up to 5 cm Limited to once per tooth per lifetime	See fee schedule	See fee schedule
Complicated suture - up to 5 cm Limited to once per tooth per lifetime	See fee schedule	See fee schedule
Complicated suture - greater than 5 cm Limited to once per tooth per lifetime	See fee schedule	See fee schedule
Sialolithotomy Limited to once per tooth per lifetime	See fee schedule	See fee schedule
Closure of salivary fistula Limited to once per tooth per lifetime	See fee schedule	See fee schedule
ADJUNCTIVE SERVICES		
Desensitizing Medicament	See fee schedule	See fee schedule
General Anesthesia Covered when Necessary in	See fee schedule	See fee schedule

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.		
Local Anesthesia Not Covered in conjunction with operative or surgical procedure.	See fee schedule	See fee schedule
Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report Limited to 1 per visit.	See fee schedule	See fee schedule
Occlusal Adjustment	See fee schedule	See fee schedule
Occlusal Guards Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.	See fee schedule	See fee schedule
Occlusal Guard Reline and Repair Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	See fee schedule	See fee schedule
Occlusion Analysis - Mounted Case Limited to 1 time per consecutive 60 months.	See fee schedule	See fee schedule
Palliative Treatment Covered as a separate benefit only if no other services, other	See fee schedule	See fee schedule

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
than exam and radiographs, were done on the same tooth during the visit.		
Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.) Limited to 1 of these procedures per 1 provider.	See fee schedule	See fee schedule
MAJOR RESTORATIVE SERVICES		
Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Crowns - Retainers/Abutments Limited to once every 5 years. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	See fee schedule	See fee schedule
Crowns - Restorations Limited to once every 5 years. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	See fee schedule	See fee schedule
Temporary Crowns - Restorations Limited to once every 5 years. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	See fee schedule	See fee schedule

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Inlays/Onlays - Retainers/Abutments Limited to once every 5 years. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	See fee schedule	See fee schedule
Inlays/Onlays - Restorations Limited to once every 5 years. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	See fee schedule	See fee schedule
Pontics Limited to 1 time per tooth per consecutive 60 months.	See fee schedule	See fee schedule
Retainer-Cast Metal for Resin Bonded Fixed Prosthesis Limited to 1 time per tooth per consecutive 60 months.	See fee schedule	See fee schedule
Pin Retention Limited to 2 pins per tooth; not covered in addition to cast restoration.	See fee schedule	See fee schedule
Post and Cores Covered only for teeth that have had root canal therapy.	See fee schedule	See fee schedule
Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core Limited to those performed more than 12 months after the initial	See fee schedule	See fee schedule

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
insertion.		
Sedative Filling Covered as a separate benefit only if no other service, other than x-rays and exam, were done on the same tooth during the visit.	See fee schedule	See fee schedule
Stainless Steel Crowns Limited to once every 5 years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	See fee schedule	See fee schedule
Implant/abutment supported removable denture for completely edentulous arch Once per 5 calendar years.	See fee schedule	See fee schedule
Implant/abutment supported removable denture for partially edentulous arch Once per 5 calendar years.	See fee schedule	See fee schedule
Abutment supported porcelain/ceramic crown Once per 5 calendar years.	See fee schedule	See fee schedule
Abutment supported porcelain fused to metal crown (high noble metal) Once per 5 calendar years.	See fee schedule	See fee schedule
Abutment supported porcelain fused to metal crown (predominately base metal) Once per 5 calendar years.	See fee schedule	See fee schedule

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Abutment supported porcelain fused to metal crown (noble metal) Once per 5 calendar years.	See fee schedule	See fee schedule
Abutment supported cast metal crown (high noble metal) Once per 5 calendar years.	See fee schedule	See fee schedule
Abutment supported cast metal crown (predominately base metal) Once per 5 calendar years.	See fee schedule	See fee schedule
Abutment supported cast metal crown (noble metal) Once per 5 calendar years.	See fee schedule	See fee schedule
Implant supported porcelain/ceramic crown Once per 5 calendar years.	See fee schedule	See fee schedule
Implant supported porcelain fused to metal crown Once per 5 calendar years.	See fee schedule	See fee schedule
Implant supported metal crown Once per 5 calendar years.	See fee schedule	See fee schedule
Abutment supported retainer for porcelain/ceramic FPD Once per 5 calendar years.	See fee schedule	See fee schedule
Abutment supported retainer for porcelain fused to metal FPD (high noble metal) Once per 5 calendar years.	See fee schedule	See fee schedule
Abutment supported retainer for porcelain fused to metal FPD	See fee schedule	See fee schedule

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
(predominately base metal) Once per 5 calendar years.		
Abutment supported retainer for porcelain fused to metal FPD (noble metal) Once per 5 calendar years.	See fee schedule	See fee schedule
Abutment supported retainer for cast metal FPD (high noble metal) Once per 5 calendar years.	See fee schedule	See fee schedule
Abutment supported retainer for cast metal FPD (predominately base metal) Once per 5 calendar years.	See fee schedule	See fee schedule
Abutment supported retainer for cast metal FPD (noble metal) Once per 5 calendar years.	See fee schedule	See fee schedule
Implant supported retainer for ceramic FPD Once per 5 calendar years.	See fee schedule	See fee schedule
Implant supported retainer for porcelain fused to metal FPD Once per 5 calendar years.	See fee schedule	See fee schedule
Implant supported retainer for case metal FPD Once per 5 calendar years.	See fee schedule	See fee schedule
Implant/abutment supported fixed denture for completely edentulous arch Once per 5 calendar years.	See fee schedule	See fee schedule
Implant/abutment supported fixed denture for partially edentulous arch	See fee schedule	See fee schedule

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Once per 5 calendar years.		
Recent implant/abutment supported crown Once per 5 calendar years.	See fee schedule	See fee schedule
Recent implant/abutment supported fixed partial denture Once per 5 calendar years.	See fee schedule	See fee schedule
Abutment supported crown - titanium Once per 5 calendar years.	See fee schedule	See fee schedule
Abutment supported retainer crown for FPD - titanium Once per 5 calendar years.	See fee schedule	See fee schedule
Stress breaker - covered under crown / bridge Once per 5 calendar years.	See fee schedule	See fee schedule
FIXED PROSTHETICS		
Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Fixed Partial Dentures (Bridges) Limited to 1 time per tooth per consecutive 60 months.	See fee schedule	See fee schedule
REMOVABLE PROSTHETICS		
Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Full Dentures Limited to once per 5 years. No additional allowances for precision or semi-precision attachments.	See fee schedule	See fee schedule

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Partial Dentures Limited to once per 5 years. No additional allowances for precision or semi-precision attachments.	See fee schedule	See fee schedule
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 5 years.	See fee schedule	See fee schedule
Tissue Conditioning - Maxillary or Mandibular Limited to once per 5 years.	See fee schedule	See fee schedule
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to once per 5 years.	See fee schedule	See fee schedule

TYPE 1 PROCEDURE

Fee Schedule BENEFIT PERIOD- Calendar Year

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation- established patient.

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.

D0150 Comprehensive oral evaluation- new or established patient.

D0180 Comprehensive periodontal evaluation- new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures.
- In addition D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145 also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180 also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC FILM

D0210 Intraoral – complete series (including bitewings).

D0330 Panoramic film.

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS

D0220 Intraoral – periapical first film.

D0230 Intraoral- periapical each additional film.

D0240 Intraoral- occlusal film.

D0250 Extraoral - first film.

D0260 Extraoral -each additional film.

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

TYPE 1 PROCEDURE

BITEWING FILMS

- D0270 Bitewing - single film.
- D0272 Bitewings – two films.
- D0273 Bitewings- three film.
- D0274 Bitewings- four films.
- D0277 Vertical bitewings- 7 to 8 films.

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277 also contribute(s) to this limitation
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILMS: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLOURIDE

- D1110 Prophylaxis -adult.
- D1120 Prophylaxis-child.
- D1203 Topical application of fluoride (prophylaxis not included) - child.
- D1204 Topical application of fluoride (prophylaxis not included) adult.
- D1206 Topical fluoride varnish: therapeutic application for moderate to high caries risk patients.

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910 also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 13 and over. A child prophylaxis (cleaning) is considered for individuals age 12 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.
- An additional adult prophylaxis (cleaning) is considered for a Pregnant Participant 1 per benefit period.

SEALANT

- D1351 Sealant - per tooth.

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

TYPE 1 PROCEDURES

SPACE MAINTAINERS

D1510 Space maintainer- fixed- unilateral.

D1515 Space maintainer- fixed- bilateral.

D1520 Space maintainer- removable- unilateral.

D1525 Space maintainer- removable- bilateral.

D1550 R-cementation of space maintainer.

D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Benefits are considered for persons age 12 and under.
- Coverage is limited to space maintenance for unerupted teeth following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210 Removable appliance therapy.

D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking

TYPE 2 PROCEDURES
Fee Schedule
BENEFIT PERIOD- Calendar Year

LIMITED ORAL EVALUATION	Maximum Covered Expense
D0140 Limited oral evaluation - problem focused.	\$20.00
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).	\$20.00

LIMITED ORAL EVALUATION: D0140
 Included with exam frequency limitations 0120, 0145, 0150 & 0180

LIMITED ORAL RE-EVALUATIONS: D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a 00120/00145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.	\$24.00
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	\$48.00
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	\$48.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.	\$35.00
D2150 Amalgam- two surfaces, primary or permanent.	\$44.00
D2160 Amalgam - three surfaces, primary or permanent	\$54.00
D2161 Amalgam - four or more surfaces, primary or permanent.	\$64.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394. Also contribute(s) to this limitation.

TYPE 2 PROCEDURES

**Maximum Covered
Expense**

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.	\$43.00
D2331 Resin-based composite- two surface, anterior.	\$54.00
D2332 Resin-based composite- three surfaces, anterior.	\$67.00
D2335 Resin-based composite- four or more surfaces or involving incisal angle (anterior).	\$74.00
D2391 Resin-based composite - one surface, posterior.	\$47.00
D2392 Resin-based composite- two surfaces, posterior.	\$59.00
D2393 Resin-based composite- three surfaces, posterior.	\$74.00
D2394 Resin-based composite- four or more surfaces, posterior.	\$82.00
D2410 Gold foil- one surface.	\$35.00
D2420 Gold foil- two surfaces.	\$44.00
D2430 Gold foil- three surfaces.	\$54.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393. D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.	\$90.00
D2930 Prefabricated stainless steel crown- primary tooth.	\$76.00
D2931 Prefabricated stainless steel crown- permanent tooth.	\$80.00
D2932 Prefabricated resin crown.	\$90.00
D2933 Prefabricated stainless steel crown with resin window.	\$90.00
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.	\$90.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).

RECEMENT

D2910 Recement inlay, onlay, or partial coverage restoration.	\$28.00
D2915 Recement cast or prefabricated post and core.	\$14.00
D2920 Recement crown.	\$27.00
D6092 Recement implant/abutment supported crown.	\$27.00
D6093 Recement implant/abutment supported fixed partial denture.	\$27.00
D6930 Recement fixed partial denture.	\$38.00

TYPE 2 PROCEDURES

	Maximum Covered Expense
SEDATIVE FILLING	
D2940 Sedative filling.	\$26.00
FULL MOUTH DEBRIDEMENT	
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.	\$43.00
FULL MOUTH DEBRIDEMENT: D4355	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 12 month(s). 	
PERIODONTAL MAINTENANCE	
D4910 Periodontal maintenance.	\$44.00
PERIODONTAL MAINTENANCE: D4910	
<ul style="list-style-type: none"> • Coverage is limited to 2 of any of these procedures per 1 benefit period. • D1110, D1120, also contribute(s) to this limitation. • Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure. 	
DENTURE REPAIR	
D5510 Repair broken complete denture base.	\$44.00
D5520 Replace missing or broken teeth- complete denture (each tooth).	\$37.00
D5610 Repair resin denture base.	\$44.00
D5620 Repair cast framework.	\$52.00
D5630 Repair or replace broken clasp.	\$54.00
D5640 Replace broken teeth - per tooth.	\$39.00
DENTURE RELINES	
D5730 Reline complete maxillary denture (chairside).	\$82.00
D5731 Reline complete mandibular denture (chairside).	\$81.00
D5740 Reline maxillary partial denture (chairside).	\$73.00
D5741 Reline mandibular partial denture (chairside).	\$73.00
D5750 Reline complete maxillary denture (laboratory).	\$121.00
D5751 Reline complete mandibular denture (laboratory).	\$119.00
D5760 Reline maxillary partial denture (laboratory).	\$121.00
D5761 Reline mandibular partial denture (laboratory).	\$122.00
DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761	
<ul style="list-style-type: none"> • Coverage is limited to service dates more than 6 months after placement date. 	

TYPE 2 PROCEDURES

	Maximum Covered Expense
NON-SURGICAL EXTRACTIONS	
D7111 Extraction, coronal remnants- deciduous tooth.	\$39.00
07140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	\$39.00
SURGICAL EXTRACTIONS	
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	\$75.00
D7220 Removal of impacted tooth- soft tissue.	\$94.00
D7230 Removal of impacted tooth - partially bony.	\$125.00
D7240 Removal of impacted tooth - completely bony .	\$146.00
D7241 Removal of impacted tooth- completely bony, with unusual surgical complications.	\$166.00
D7250 Surgical removal of residual tooth roots (cutting procedure).	\$78.00
OTHER ORAL SURGERY	
D7260 Oriental fistula closure.	\$184.00
D7261 Primary closure of a sinus perforation.	\$184.00
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	\$111.00
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	\$111.00
D7280 Surgical access of an unerupted tooth.	\$173.00
D7282 Mobilization of erupted or mal positioned tooth to aid eruption.	\$124.00
D7283 Placement of device to facilitate eruption of impacted tooth.	\$52.00
D7310 Alveoplasty in conjunction with extractions- four or more teeth or tooth spaces, per quadrant.	\$65.00
D7311 Alveoplasty in conjunction with extractions- one to three teeth or tooth spaces, per quadrant.	\$33.00
D7320 Alveoplasty not in conjunction with extractions- four or more teeth or tooth spaces, per quadrant.	\$82.00
D7321 Alveoplasty not in conjunction with extractions one to three teeth or tooth spaces, per quadrant.	\$41.00
D7340 Vestibuloplasty- ridge extension (secondary epithelialization).	\$119.00
D7350 Vestibuloplasty ridge extension (including soft tissue grafts. muscle reattachment. revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	\$296.00
D7410 Excision of benign lesion up to 1.25 cm.	\$118.00
D7411 Excision of benign lesion greater than 1.25 cm.	\$151.00
D7412 Excision of benign lesion, complicated.	\$166.00
D7413 Excision of malignant lesion up to 1.25 cm.	\$159.00
D7414 Excision of malignant lesion greater than 1.25 cm.	\$117.00
D7415 Excision of malignant lesion, complicated.	\$128.00
D7440 Excision of malignant tumor- lesion diameter up to 1.25 cm.	\$159.00

TYPE 2 PROCEDURES

	Maximum Covered Expense
D7441 Excision of malignant tumor -lesion diameter greater than 1.25 cm.	\$117.00
D7450 Removal of benign odontogenic cyst or tumor- lesion diameter up to 1.25 cm.	\$118.00
D7451 Removal of benign odontogenic cyst or tumor- lesion diameter greater than 1.25 cm.	\$151.00
D7460 Removal of benign nonodontogenic cyst or tumor- lesion diameter up to 1.25 cm.	\$118.00
D7461 Removal of benign nonodontogenic cyst or tumor- lesion diameter greater than 1.25 cm.	\$151.00
D7465 Destruction of lesion(s) by physical or chemical method, by report.	\$36.00
D7471 Removal of lateral exostosis (maxilla or mandible).	\$105.00
D7472 Removal of torus palatinus.	\$105.00
D7473 Removal of torus mandibularis.	\$105.00
D7485 Surgical reduction of osseous tuberosity.	\$171.00
D7490 Radical resection of maxilla or mandible.	\$159.00
D7510 Incision and drainage of abscess- intraoral soft tissue.	\$52.00
D7520 Incision and drainage of abscess- extraoral soft tissue.	\$61.00
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	\$48.00
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.	\$133.00
D7550 Partial osteotomy/sequestrectomy for removal of non-vital bone.	\$133.00
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.	\$175.00
D7910 Suture of recent small wounds up to 5 cm.	\$23.00
D7911 Complicated suture- up to 5 cm.	\$26.00
D7912 Complicated suture- greater than 5 cm.	\$38.00
D7960 Frenulectomy (frenectomy or frenotomy) - separate procedure.	\$127.00
D7963 Frenuloplasty.	\$158.00
D7970 Excision of hyperplastic tissue- per arch.	\$97.00
D7972 Surgical reduction of fibrous tuberosity.	\$155.00
D7980 Sialolithotomy.	\$146.00
D7983 Closure of salivary fistula.	\$47.00
REMOVAL OF BONE TISSUE: D7471, D7472, D7473	
• Coverage is limited to 5 of any of these procedures per lifetime.	
BIOPSY OF ORAL TISSUE	
D7285 Biopsy of oral tissue- hard (bone, tooth).	\$158.00
D7286 Biopsy of oral tissue- soft.	\$85.00
D7287 Exfoliative cytological sample collection.	\$43.00
D7288 Brush biopsy - transepithelial sample collection.	\$43.00

TYPE 2 PROCEDURES

	Maximum Covered Expense
PALLIATIVE	
D9110 Palliative (emergency) treatment of dental pain- minor procedure.	\$29.00
PALLIATIVE TREATMENT: D9110	
<ul style="list-style-type: none"> • Not covered in conjunction with other procedures, except diagnostic x-ray films. 	
ANESTHESIA-GENERAL/IV	
D9220 Deep sedation/general anesthesia- first 30 minutes.	\$112.00
D9221 Deep sedation/general anesthesia- each additional 15 minutes.	\$37.00
D9241 Intravenous conscious sedation/analgesia- first 30 minutes.	\$74.00
D9242 Intravenous conscious sedation/analgesia- each additional 15 minutes.	\$18.00
GENERAL ANESTHESIA: D9220, D9221, D9241, D9242	
<ul style="list-style-type: none"> • Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered. 	
PROFESSIONAL CONSULT/VISIT/SERVICES	
D9310 Consultation- diagnostic service provided by dentist or physician other than requesting dentist or physician.	\$30.00
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.	\$20.00
D9440 Office visit- after regularly scheduled hours.	\$36.00
D9930 Treatment of complications (post-surgical)-unusual circumstances, by report.	\$22.00
CONSULTATION: D9310	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 1 provider. 	
OFFICE VISIT: D9430, D9440	
<ul style="list-style-type: none"> • Procedure D9430 is allowed for accidental injury only, Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater. 	
MISCELLANEOUS	
D0486 Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report.	\$24.00
D2951 Pin retention- per tooth, in addition to restoration.	\$13.00
D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.	\$43.00
DESENSITIZATION: D9911	
<ul style="list-style-type: none"> • Coverage is limited to 1 of any of these procedures per 6 month(s). • D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394 also contribute(s) to this limitation. • Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations. 	

TYPE 3 PROCEDURES

Fee Schedule

BENEFIT PERIOD- Calendar Year

	Maximum Covered
INLAY RESTORATIONS	Expense
D2510 Inlay- metallic- one surface.	\$114.00
D2520 Inlay- metallic- two surfaces.	\$136.00
D2530 Inlay -metallic- three or more surfaces.	\$147.00
D2610 Inlay- porcelain/ceramic- one surface.	\$126.00
D2620 Inlay- porcelain/ceramic- two surfaces.	\$137.00
D2630 Inlay- porcelain/ceramic- three or more surfaces.	\$150.00
D2650 Inlay - resin-based composite - one surface.	\$131.00
D2651 Inlay - resin-based composite- two surfaces.	\$129.00
D2652 Inlay - resin-based composite - three or more surfaces.	\$134.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS

D2542 Onlay- metallic- two surfaces.	\$148.00
D2543 Onlay- metallic- three surfaces.	\$165.00
D2544 Onlay- metallic- four or more surfaces.	\$172.00
D2642 Onlay - porcelain/ceramic - two surfaces.	\$148.00
D2643 Onlay - porcelain/ceramic - three surfaces.	\$166.00
D2644 Onlay - porcelain/ceramic - four or more surfaces.	\$171.00
D2662 Onlay- resin-based composite- two surfaces.	\$139.00
D2663 Onlay - resin-based composite - three surfaces.	\$143.00
D2664 Onlay- resin-based composite- four or more surfaces.	\$152.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783,
- D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

TYPE 3 PROCEDURES

- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS	Maximum Covered Expense
D2710 Crown- resin-based composite (indirect).	\$65.00
D2712 Crown- 3/4 resin-based composite (indirect).	\$161.00
D2720 Crown - resin with high noble metal.	\$165.00
D2721 Crown - resin with predominantly base metal.	\$126.00
D2722 Crown- resin with noble metal.	\$155.00
D2740 Crown- porcelain/ceramic substrate.	\$179.00
D2750 Crown- porcelain fused to high noble metal.	\$174.00
D2751 Crown- porcelain fused to predominantly base metal.	\$149.00
D2752 Crown- porcelain fused to noble metal	\$160.00
D2780 Crown- 3/4 cast high noble metal.	\$165.00
D2781 Crown- 3/4 cast predominantly base metal.	\$144.00
D2782 Crown- 3/4 cast noble metal.	\$150.00
D2783 Crown- 3/4 porcelain/ceramic.	\$179.00
D2790 Crown- full cast high noble metal.	\$165.00
D2791 Crown- full cast predominantly base metal.	\$144.00
D2792 Crown- full cast noble metal.	\$150.00
D2794 Crown- titanium.	\$165.00

CROWN: D2710, D2712, D2720, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup including any pins.	\$36.00
D6973 Core build up for retainer, including any pins.	\$36.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
POST AND CORE	
D2952 Post and core in addition to crown, indirectly fabricated.	\$57.00
D2954 Prefabricated post and core in addition to crown.	\$48.00
FIXED CROWN AND PARTIAL DENTURE REPAIR	
D2980 Crown repair, by report.	\$29.00
D6980 Fixed partial denture repair, by report.	\$32.00
D9120 Fixed partial denture sectioning.	\$32.00
ENDODONTICS MISCELLANEOUS	
D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	\$23.00
D3221 Pulpal debridement, primary and permanent teeth.	\$23.00
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	\$30.00
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	\$26.00
D3333 Internal root repair of perforation defects.	\$37.00
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$37.00
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	\$25.00
D3353 Apexification/recalcification- final visit (includes completed root canal therapy- apical closure/calcific repair of perforations, root resorption, etc.).	\$74.00
D3430 Retrograde filling - per root.	\$29.00
D3450 Root amputation - per root.	\$69.00
D3920 Hemisection (including any root removal), not including root canal therapy.	\$59.00
ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920	
• Procedure D3333 is limited to permanent teeth only.	
PULPOTOMY/PULPAL DEBRIDEMENT/PULPAL THERAPY: D3220, D3221, D3230, D3240	
• Procedure D3220 is limited to primary teeth.	
ENDODONTIC THERAPY (ROOT CANALS)	
D3310 Anterior (excluding final restoration).	\$104.00
D3320 Bicuspid (excluding final restoration).	\$122.00
D3330 Molar (excluding final restoration).	\$160.00
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	\$61.00
D3346 Retreatment of previous root canal therapy- anterior.	\$129.00
D3347 Retreatment of previous root canal therapy- bicuspid.	\$149.00

TYPE 3 PROCEDURES

D3348 Retreatment of previous root canal therapy - molar. \$185.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RE-TREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410 Apicoectomy/periradicular surgery- anterior. \$107.00

D3421 Apicoectomy/periradicular surgery- bicuspid (first root). \$123.00

D3425 Apicoectomy/periradicular surgery- molar (first root). \$133.00

D3426 Apicoectomy/periradicular surgery (each additional root). \$48.00

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty- four or more contiguous teeth or bounded teeth spaces per quadrant. \$68.00

D4211 Gingivectomy or gingivoplasty- one to three contiguous teeth or bounded teeth spaces per quadrant. \$34.00

D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant. \$93.00

D4241 Gingival flap procedure, including root planing- one to three contiguous teeth or bounded teeth spaces per quadrant. \$47.00

D4260 Osseous surgery (including flap entry and closure)- four or more contiguous teeth or bounded teeth spaces per quadrant. \$170.00

D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant. \$85.00

D4263 Bone replacement graft- first site in quadrant. \$56.00

D4264 Bone replacement graft- each additional site in quadrant. \$42.00

D4265 Biologic materials to aid in soft and osseous tissue regeneration. \$28.00

D4270 Pedicle soft tissue graft procedure. \$125.00

D4271 Free soft tissue graft procedure (including donor site surgery). \$133.00

D4273 Subepithelial connective tissue graft procedures, per tooth. \$155.00

D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area). \$75.00

TYPE 3 PROCEDURES

Maximum Covered Expense

D4275 Soft tissue allograft.	\$133.00
D4276 Combined connective tissue and double pedicle graft, per tooth.	\$155.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 1 of any of these procedures per 2 year(s).
- Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING

D4249 Clinical crown lengthening- hard tissue.	\$102.00
--	----------

NON-SURGICAL PERIODONTICS

D4341 Periodontal scaling and root planing - four or more teeth per quadrant.	\$35.00
D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.	\$17.00
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	\$26.00

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 1 of any of these procedures per 12 month(s).
- A scaling and root planing or periodontal maintenance procedure must be performed in this quadrant within 2 years prior to the date of service for this procedure.

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 12 month(s) with 1 additional for a pregnant Participant.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture- maxillary.	\$185.00
D5120 Complete denture - mandibular.	\$179.00
D5130 Immediate denture- maxillary.	\$200.00
D5140 Immediate denture- mandibular.	\$194.00
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	\$133.00
D5212 Mandibular partial denture- resin base (including any conventional clasps, rests and teeth).	\$154.00

TYPE 3 PROCEDURES

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$214.00
D5214	Mandibular partial denture- cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	\$214.00
D5225	Maxillary partial denture- flexible base (including any clasps, rests and teeth).	\$133.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	\$154.00
D5281	Removable unilateral partial denture- one piece cast metal (including clasps and teeth).	\$115.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	\$133.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	\$154.00
D5810	Interim complete denture (maxillary).	\$82.00
D5811	Interim complete denture (mandibular).	\$86.00
D5820	Interim partial denture (maxillary).	\$72.00
D5821	Interim partial denture (mandibular).	\$75.00
D5860	Overdenture- complete, by report.	\$185.00
D5861	Overdenture- partial, by report.	\$214.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	\$185.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	\$214.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	\$185.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	\$214.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861,

D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410	Adjust complete denture- maxillary.	\$10.00
D5411	Adjust complete denture- mandibular.	\$10.00
D5421	Adjust partial denture- maxillary.	\$11.00
D5422	Adjust partial denture- mandibular.	\$10.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

TYPE 3 PROCEDURES

- Coverage is limited to dates of service more than 6 months after placement date.

	Maximum Covered Expense
ADD TOOTH/CLASP TO EXISTING PARTIAL	
D5650 Add tooth to existing partial denture.	\$24.00
D5660 Add clasp to existing partial denture.	\$28.00
DENTURE REBASES	
D5710 Rebase complete maxillary denture.	\$67.00
D5711 Rebase complete mandibular denture.	\$71.00
D5720 Rebase maxillary partial denture.	\$64.00
D5721 Rebase mandibular partial denture.	\$68.00
TISSUE CONDITIONING	
D5850 Tissue conditioning, maxillary.	\$19.00
D5851 Tissue conditioning, mandibular.	\$20.00
PROSTHODONTICS – FIXED	
D6058 Abutment supported porcelain/ceramic crown.	\$154.00
D6059 Abutment supported porcelain fused to metal crown (high noble metal).	\$168.00
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).	\$168.00
D6061 Abutment supported porcelain fused to metal crown (noble metal).	\$154.00
D6062 Abutment supported cast metal crown (high noble metal).	\$168.00
D6063 Abutment supported cast metal crown (predominantly base metal).	\$168.00
D6064 Abutment supported cast metal crown (noble metal).	\$182.00
D6065 Implant supported porcelain/ceramic crown.	\$154.00
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	\$168.00
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).	\$168.00
D6068 Abutment supported retainer for porcelain/ceramic FPD.	\$154.00
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	\$168.00
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	\$168.00
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).	\$154.00
D6072 Abutment supported retainer for cast metal FPD (high noble metal).	\$168.00
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).	\$168.00
D6074 Abutment supported retainer for cast metal FPD (noble metal).	\$182.00
D6075 Implant supported retainer for ceramic FPD.	\$154.00
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	\$168.00

TYPE 3 PROCEDURES

D6077	Implant supported retainer for cast metal FPO (titanium, titanium alloy or high noble metal).	\$168.00
D6094	Abutment supported crown- (titanium).	\$168.00
D6194	Abutment supported retainer crown for FPO- (titanium).	\$168.00
D6205	Pontic -indirect resin based composite.	\$139.00
D6210	Pontic- cast high noble metal.	\$168.00
D6211	Pontic- cast predominantly base metal.	\$168.00
D6212	Pontic -cast noble metal.	\$182.00
D6214	Pontic- titanium.	\$168.00
D6240	Pontic -porcelain fused to high noble metal.	\$168.00
D6241	Pontic- porcelain fused to predominantly base metal.	\$168.00
D6242	Pontic -porcelain fused to noble metal.	\$154.00
D6245	Pontic- porcelain/ceramic.	\$154.00
D6250	Pontic- resin with high noble metal.	\$168.00
D6251	Pontic- resin with predominantly base metal.	\$154.00
D6252	Pontic - resin with noble metal.	\$182.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	\$56.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	\$56.00
D6600	Inlay- porcelain /ceramic, two surfaces.	\$137.00
D6601	Inlay- porcelain/ceramic, three or more surfaces.	\$151.00
D6602	Inlay- cast high noble metal, two surfaces.	\$123.00
D6603	Inlay- cast high noble metal, three or more surfaces.	\$136.00
D6604	Inlay- cast predominantly base metal, two surfaces.	\$107.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	\$117.00
D6606	Inlay- cast noble metal, two surfaces.	\$112.00
D6607	Inlay- cast noble metal, three or more surfaces.	\$123.00
D6608	Onlay - porcelain/ceramic, two surfaces.	\$148.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	\$163.00
D6610	Onlay - cast high noble metal, two surfaces.	\$136.00
D6611	Onlay- cast high noble metal, three or more surfaces.	\$149.00
D6612	Onlay- cast predominantly base metal, two surfaces.	\$117.00
D6613	Onlay- cast predominantly base metal, three or more surfaces.	\$129.00
D6614	Onlay - cast noble metal, two surfaces.	\$123.00
D6615	Onlay - cast noble metal, three or more surfaces.	\$136.00
D6624	Inlay- titanium.	\$136.00

TYPE 3 PROCEDURES

	Maximum Covered Expense
D6634 Onlay- titanium.	\$149.00
D6710 Crown - indirect resin based composite.	\$139.00
D6720 Crown - resin with high noble metal.	\$168.00
D6721 Crown- resin with predominantly base metal.	\$87.00
D6722 Crown - resin with noble metal.	\$140.00
D6740 Crown - porcelain/ceramic.	\$154.00
D6750 Crown- porcelain fused to high noble metal.	\$182.00
D6751 Crown- porcelain fused to predominantly base metal.	\$168.00
D6752 Crown - porcelain fused to noble metal.	\$154.00
D6780 Crown - 3/4 cast high noble metal.	\$182.00
D6781 Crown - 3/4 cast predominantly base metal.	\$168.00
D6782 Crown - 3/4 cast noble metal.	\$154.00
D6783 Crown - 3/4 porcelain/ceramic.	\$154.00
D6790 Crown - full cast high noble metal.	\$168.00
D6791 Crown- full cast predominantly base metal.	\$168.00
D6792 Crown - full cast noble metal.	\$154.00
D6794 Crown - titanium.	\$168.00
D6940 Stress breaker.	\$47.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780.

D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).

TYPE 3 PROCEDURES

- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245,

D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065,

D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074,

D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.

CAST POST AND CORE FOR PARTIALS

Maximum Covered

Expense

D6970 Post and core in addition to fixed partial denture retainer, indirectly fabricated.

\$50.00

D6972 Prefabricated post and core in addition to fixed partial denture retainer.

\$50.00

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment- limited.

\$13.00

D9952 Occlusal adjustment- complete.

\$68.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

Dependent Coverage Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide coverage for Dependents.

1. The Dependent Definition in the *Certificate of Coverage, Section 1: Definitions* is replaced with the following:

Dependent - (1.) the Subscriber's legal spouse, or (2.) a dependent child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, a legally adopted child, a child placed for adoption, or a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse). The term child also includes a grandchild who is in the legal custody of either the Subscriber or the Subscriber's spouse. To be eligible for coverage under the Policy, a Dependent must reside within the United States. The definition of Dependent is subject to the following conditions and limitations:

- A. The term Dependent will not include any dependent child 26 years of age or older, except as stated in *Section 3: Termination of Coverage, sub-section 3.2: Extended Coverage for Handicapped Children*.

The Subscriber agrees to reimburse the Company for any Dental Services provided to the child at a time when the child did not satisfy these conditions.

The term Dependent also includes a child for whom dental care coverage is required through a Qualified Medical Child Support Order or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

The term Dependent does not include anyone who is also enrolled as a Subscriber, nor can anyone be a Dependent of more than one Subscriber.

This amendment is subject to applicable terms and conditions of the Policy. All other provisions of the Policy remain unchanged.

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

UNITEDHEALTHCARE DENTAL

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective: April 14, 2003

We* are required by law to protect the privacy of your health information. We are also required to send you this notice which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider or health plan that related to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our web site www.uhcspecialtybenefits.com.

*For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following UnitedHealthcare entities: ACN Group of California, Inc.; All Savers Insurance Company; AmeriChoice of New Jersey, Inc.; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, In.; Dental Benefit Providers of California, Inc.; Dental benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Dental Benefit Providers of New Jersey, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; Investors Guaranty Life Insurance Company; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Nevada Pacific Dental, Inc.; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Optimum Choice, Inc. of Pennsylvania; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; Pacific Union Dental, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc., UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Tennessee, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of Ohio; and U.S. Behavioral Health Plan, California.

How We Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- **For Payment** of premiums due us and to process claims for health care services you receive.
- **For Treatment.** We may disclose health information to your doctors or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- **To Plan Sponsors.** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.
- **For Appointment Reminders.** We may use health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers compensation laws of job-related injuries.
- **Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

If none of the above reasons apply, **then we must get your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by

other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, refer to "Exercising Your Rights" on page 4 of this notice.

Highly Confidential Information

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;
- Sexually transmitted diseases and reproductive health information; and
- Child or adult abuse or neglect, including sexual assault.

Attached to this notice is a *Summary of State Laws on Use and Disclosure of Certain Types of Medical Information*.

What Are Your Rights

The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. box instead of your home address).
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.
- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting.

- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.uhcspecialtybenefits.com

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the phone number on your ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

UnitedHealthcare
Customer Service - Privacy Unit
PO Box 740815
Atlanta, GA 30374-0815

You may also notify the *Secretary of the U.S. Department of Health and Human Services* of your complaint. We will not take any action against you for filing a complaint.

Financial Information Privacy Notice

We (including our affiliates listed at the bottom of this page)** are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your personal financial information.

**For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities on the first page of the Notice of Privacy Practices, plus the following UnitedHealthcare affiliates: A CN Group, Inc.; ACN Group IPA of New York, Inc.; Alliance Recovery Services, LLC; AmeriChoice Health Services, Inc.; Behavioral Health Administrators; Continental Plan Services, Inc.; Coordinated Vision Care, Inc.; DBP-KAI, Inc.; Disability Consulting Group, LLC; DCG Resource Options, LLC; Definity Health Corporation; Definity Health of New York, Inc.; Dental Benefit Providers, Inc.; Dental Insurance Company of America; Exante Bank, Inc.; Fidelity Benefit Administrators, Inc.; HealthAllies, Inc.; IBA Self Funded Group, Inc.; Illinois Pacific Dental, Inc.; Lifemark Corporation; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; Midwest Security Administrators, Inc.; Midwest Security Care, Inc.; National Benefit Resources, Inc.; NPD Dental Services; NPD Insurance Company, Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Pacific Dental Benefits; PacifiCare Behavioral Health NY IPA, Inc.; PacifiCare Health Plan Administrators, Inc.; ProcessWorks, Inc.; Spectera of New York, IPA, Inc.; Uniprise, Inc.; United Behavioral Health of New York, I.P.A., Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Services, Inc.; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthcare Service LLC; United Medical Resources, Inc.*

Summary of State Laws on Use and Disclosure of Certain Types of Medical Information

This information is intended to provide an overview of state laws that are more stringent than the federal *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules* with respect to the use or disclosure of protected health information in the categories listed below.

Sexually Transmitted Diseases and Reproductive Health	
Disclosure of sexually transmitted diseases and reproductive health related information may be: (1) limited to specified circumstances; and/or (2) restricted by the patient.	HI, MS, NM, NY, NC, OK, WA, VA
Disclosure of sexually transmitted diseases and reproductive health information must be accompanied by a written statement meeting certain requirements.	NM
There are specific requirements that must be followed when an insurer uses or requests sexually transmitted disease tests or reproductive health information for insurance or underwriting purposes.	MS
Alcohol and Drug Abuse	
Disclosure of alcohol and drug abuse information may be: (1) limited to specified circumstances; (2) restricted by the patient; and/or (3) prohibited under certain circumstances.	GA, HI, KY, MA, NH, OK, VA, WA, WI
A specific written statement must accompany any alcohol and drug abuse information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests drug and alcohol tests or information for insurance or underwriting purposes.	KY, VA
Genetic Information	
An authorization is required for each disclosure of genetic information.	CA, HI, KY, LA, RI, TN
Genetic information may be disclosed only under specific circumstances.	AZ, CO, FL, GA, HI, IL, MD, MA, MO, NV, NH, NJ, NM, NY, OR, TX, VT
Restrictions apply to (1) the use; and/or (2) the retention of genetic information.	CO, GA, IL, NV, NJ, NM, OR, VT, WY
Specific requirements must be followed when an insurer uses or requests a genetic test for insurance or underwriting purposes.	FL, IL, IN, LA, NV, WY

HIV/AIDS	
Disclosure of HIV/AIDS related information may only be: (1) limited to specific circumstances; and/or (2) restricted by the patient.	AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KY, ME, MA, MI, NH, NJ, NM, NY, NC, OH, OK, OR, PA, TX, UT, VT, VA, WA, WV, WI
A specific written statement must accompany any HIV/AIDS related information.	AZ, CT, KY, NM, OR, PA, WV
Certain restrictions apply to the retention of HIV/AIDS related information.	MA, NH
Specific requirements must be followed when an insurer uses or requests an HIV/AIDS test for insurance or underwriting purposes.	AR, DE, FL, IA, MA, NH, PA, UT, VA, VT, WA, WV
Improper disclosure may be subject to penalties.	DE
Disclosure to the individual and/or designated physician may be required.	MA, NH
Mental Health	
Disclosure of mental health information may be: (1) limited to specific circumstances; (2) restricted by the patient; and/or (3) prohibited or prevented under certain circumstances.	AL, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, IA, KY, ME, MA, MD, MI, MN, NM, NY, OK, PA, TN, TX, VT, VA, WA, WV, WI
A specific written statement must accompany any mental health information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests mental health information for insurance or underwriting purposes.	IA, KY, ME, MA, NM, TN, VA
Child or Adult Abuse	
Abuse related information may only be disclosed under specific circumstances.	AL, LA, NM, TN, UT, VA, WI

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your enrolling group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the policy on the day before a qualifying event:

- A subscriber.
- A subscriber's enrolled dependent, including with respect to the subscriber's children, a child born to or placed for adoption with the subscriber during a period of continuation coverage under federal law.
- A subscriber's former spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

- A. Termination of the subscriber from employment with the enrolling group, for any reason other than gross misconduct.
- B. Reduction in the subscriber's hours of employment.

With respect to a subscriber's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

- A. Termination of the subscriber from employment with the enrolling group, for any reason other than the subscriber's gross misconduct.
- B. Reduction in the subscriber's hours of employment.
- C. Death of the subscriber.
- D. Divorce or legal separation of the subscriber.
- E. Loss of eligibility by an enrolled dependent who is a child.
- F. Entitlement of the subscriber to Medicare benefits.
- G. The enrolling group filing for bankruptcy, under Title 11, United States Code. This is also a qualifying event for any retired subscriber and his or her enrolled dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

Notification Requirements for Qualifying Event

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator within 60 days of the latest of the date of the following events:

- The subscriber's divorce or legal separation, or an enrolled dependent's loss of eligibility as an enrolled dependent.
- The date the Qualified Beneficiary would lose coverage under the policy.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The subscriber or other Qualified Beneficiary must also notify the enrolling group's plan administrator when a second qualifying event occurs, which may extend continuation coverage.

If the subscriber or other Qualified Beneficiary fails to notify the enrolling group's plan administrator of these events within the 60 day period, the plan administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a subscriber is continuing coverage under federal law, the subscriber must notify the enrolling group's plan administrator within 60 days of the birth or adoption of a child.

Notification Requirements for Disability Determination or Change in Disability Status

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator as described under "Terminating Events for Continuation Coverage under Federal Law (COBRA)," subsection A. below.

The notice requirements will be satisfied by providing written notice to the enrolling group's plan administrator. The contents of the notice must be such that the plan administrator is able to determine the covered employee and Qualified Beneficiary or beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the subscriber or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the enrolling group's plan administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the plan administrator.

The Qualified Beneficiary's initial premium due to the plan administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If you qualify or may qualify for assistance under the Trade Act of 1974, contact the enrolling group for additional information. You must contact the enrolling group promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that plan coverage was lost but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the policy will end on the earliest of the following dates:

- A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the subscriber's employment was terminated or hours were reduced (i.e., qualifying event A.).

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

- Notice of such disability must be provided within the latest of 60 days after:
 - the determination of the disability; or
 - the date of the qualifying event; or
 - the date the Qualified Beneficiary would lose coverage under the policy; and
 - in no event later than the end of the first eighteen months.
- The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.
- If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

- B. Thirty-six months from the date of the qualifying event for an enrolled dependent whose coverage ended because of the death of the subscriber, divorce or legal separation of the subscriber, or loss of eligibility by an enrolled dependent who is a child (i.e. qualifying events C., D., or E.).
- C. With respect to Qualified Beneficiaries, and to the extent that the subscriber was entitled to Medicare prior to the qualifying event:
- Eighteen months from the date of the subscriber's Medicare entitlement; or
 - Thirty-six months from the date of the subscriber's Medicare entitlement, if a second qualifying event (that was due to either the subscriber's termination of employment or the subscriber's work hours being reduced) occurs prior to the expiration of the eighteen months.
- D. With respect to Qualified Beneficiaries, and to the extent that the subscriber became entitled to Medicare subsequent to the qualifying event:
- Thirty-six months from the date of the subscriber's termination from employment or work hours being reduced (first qualifying event) if:
 - The subscriber's Medicare entitlement occurs within the eighteen month continuation period; and
 - If, absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.
- E. The date coverage terminates under the policy for failure to make timely payment of the premium.

- F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
- G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the enrolling group filed for bankruptcy, (i.e. qualifying event G.). If the Qualified Beneficiary was entitled to continuation because the enrolling group filed for bankruptcy, (i.e. qualifying event G.) and the retired subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the subscriber's death.
- H. The date the entire policy ends.
- I. The date coverage would otherwise terminate under the policy.

