DHMO Dental Plan

Dental Benefit Providers of California, Inc.

Evidence of Coverage

FOR: San Francisco Health Service System Retirees

DENTAL PLAN NUMBER: D1094

ENROLLING GROUP NUMBER: 275550

POLICY NUMBER: 752103

EFFECTIVE DATE: January 1, 2022

Offered and Underwritten by

Dental Benefit Providers of California, Inc.

Dental Benefit Providers of California, Inc.

3120 W. Lake Center Drive

Santa Ana, CA 92704

1-800-999-3367

Combined Dental Evidence of Coverage and Disclosure Form

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

The Contract 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.

Dental Benefit Providers of California, Inc. ("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 Contract. The Contract is issued on the basis of the Enrolling Group's application and payment of the required Contract Charges. The Enrolling Group's application is made a part of the Contract.

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

This combined Evidence of Coverage and Disclosure Form constitutes only a summary of the dental plan. The dental plan Contract must be consulted to determine the exact terms and conditions of coverage.

The Contract is delivered in and governed by the laws of the State of California.

Please review both the Schedule of Benefits as to benefits, copayments, coinsurance, limitations and the Evidence of Coverage for details as to the benefits, including exclusions to coverage.

Introduction

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

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

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

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 Contract in effect at that time for active or retired employees.

How To Use This EOC

This *EOC* should be read and re-read in its entirety. Many of the provisions of this *EOC* 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 *EOC* 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 *EOC* or *Schedule of Covered Dental Services* may have been changed.

Many words used in this *EOC* 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 *EOC* and *Schedule of Covered Dental Services*.

When we use the words "we," "us," and "our" in this document, we are referring to Dental Benefit Providers of California, Inc. 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 Contract may be amended. When that happens, a new *EOC*, *Schedule of Covered Dental Services* or Amendment pages for this *EOC* or *Schedule of Covered Dental Services* will be sent to you. Your *EOC* and *Schedule of Covered Dental Services* should be kept in a safe place for your future reference.

Dental Services Covered Under the Contract

In order for Dental Services to be Covered you must obtain all Dental Services directly from or through a Participating Dentist.

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

Only Necessary Dental Services are Covered under the Contract. 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 Contract.

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

The Company reserves the right to change, interpret, modify, withdraw or add benefits or terminate the Contract, 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 Contract.

The Company may, in certain circumstances for purposes of overall cost savings or efficiency, 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 arrange for various persons or entities to provide administrative services in regard to the Contract, 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 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 Contract. 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. Participating Dentists are independent practitioners and are not employees of the Company. The Company compensates its' providers using direct reimbursement, discounted fee for service, fee for service and capitation. The dentist also receives compensation from Company enrollees who pay a defined "Copayment" for specific Dental Services. In addition, there may be occasions when a program may provide supplemental payments for specific Dental Procedures. 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 Participating 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 Participating 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 Participating 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 Participating 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 Contract. 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

If, in addition to being enrolled for Coverage under the Contract, 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 Contract 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 Contract issued by the Company and you may receive a bill.

Contact the Company

Throughout this *EOC* 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.

Translation Service

The Company uses a telephone translation service for almost 140 languages and dialects. That is in addition to select Customer Service representatives who are fluent in Spanish.

Hearing And Speech Impaired Telephone Lines

The Company uses a dedicated telephone number for the hearing and speech impaired. This telephone number is 1-877-735-2929.

Public Policy Committee

The Dental Plan has established a Public Policy Committee comprised of four (4) Members of the Dental Plan, one (1) Dental Plan Dentist, an officer of the Dental Plan, and a member of the Dental Plan's Board of Directors.

The purpose of this Committee is to allow Members to make suggestions to improve the comfort, dignity, and convenience of the Members, and to indicate to the Dental Plan those areas of service in which care may be inadequate. To communicate with a member of the Committee, a Member may write the Dental Plan at 3120 W. Lake Center Drive, Santa Ana, CA 92704 or telephone the Dental Plan at 1-800-999-3367, and he or she will be given all necessary information to contact a member of the committee. Every Member's suggestion or comments will receive prompt attention.

To participate in the Dental Plan's Public Policy Committee, please submit a written request to:

Quality Management

Dental Benefit Providers of California, Inc.

3120 W. Lake Center Drive

Santa Ana, CA 92704

Dental Certificate of Coverage Table of Contents

Section 1: Definitions

This Section defines the terms used throughout this *EOC* 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 Contract. Amendments are effective only when signed by an officer of the Company. Amendments are subject to all conditions, limitations and exclusions of the Contract except for those which are specifically amended.

CDT Codes - mean the Current Dental Terminology for the current Code on Dental Procedures and Nomenclature (the Code). The Code has been designated as the national standard for reporting dental services by the Federal Government under the Health Insurance and Portability and Accountability Act of 1996 (HIPAA), and is currently recognized by third party payors nationwide.

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

Contract - the group Contract, 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.

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

Copayment - the charge you are required to pay for certain Dental Services payable under the Contract. A Copayment is a defined dollar amount. You are responsible for the payment of any Copayment 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 Dental Services Covered under the Contract, subject to the terms, conditions, limitations and exclusions of the Contract. Dental Services must be provided: (1.) when the Contract 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 Contract.

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

Dental Service or **Dental Procedures** - dental care or treatment provided by a Dentist to a Covered Person while the Contract 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. All references to the spouse of a Subscriber shall include a Domestic Partner; 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 of either the Subscriber or the Subscriber's spouse. To be eligible for Coverage under the Contract, 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.

Domestic Partner - a Registered Domestic Partner or an Unregistered Domestic Partner.

Domestic Partnership - a Registered Domestic Partnership or an Unregistered Domestic Partnership.

Eligible Expenses - Eligible Expenses for Covered Dental Services, incurred while the Contract is in effect, are the Company's contracted fee(s) for Covered Dental Services with that Dentist.

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 Contract.

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 Contract.

Enrolling Group - the employer or other defined or otherwise legally constituted group to whom the Contract 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 Contract.

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 *EOC*. The definition of Necessary used in this *EOC* 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 Participating Dentist.

Non-Participating Dentist - a Dentist who is not a participant in the Network. If you seek treatment from a Non-Participating Dentist, and have not received prior authorization from the dental plan, you will not be Covered under the dental plan for the services where there was no such prior authorization, except in certain Emergency situations.

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 Contract.

Participating Dentist - a Dentist licensed to practice dentistry in the state in which services are being provided, with whom the Company has an agreement for rendering to Subscribers the Dental Services provided by the dental plan.

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.

Premium - the periodic fee required for providing and continuing Coverage for each Subscriber and each Enrolled Dependent.

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.

Registered Domestic Partner – A person of the opposite or same sex with whom the Subscriber has established a Registered Domestic Partnership, as defined by California Family Code, Section 297-297.5 and registered pursuant to California Family Code, Section 298.

Registered Domestic Partnership – A relationship between the Subscriber and one other person of the opposite or same sex, as defined by California Family Code, Section 297-297.5 and registered pursuant to California Family Code, Section 298.

Rider - any attached description of Dental Services Covered under the Contract. 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 Contract except for those that are specifically amended.

Service Area - the region covered by the Participating Dentists. The exact Service Area for your plan may be obtained from the provider directory.

Specialist Dentist - A Participating Dentist who provides services to a Covered Person within the range of a designated specialty area of practice in which he/she is Board Eligible or Board Certified.

Subscriber - an individual who meets all applicable eligibility requirements described below and enrolls in the dental plan, and for whom prepayment has been received by the dental plan. You may enroll yourself and any eligible Dependents if you meet the dental plan eligibility requirements. To be eligible to enroll as a Subscriber you must be a member of the Enrolling Group shown on the membership card, and you must enroll within any time limitations established by your Enrolling Group.

Unregistered Domestic Partner – A person of the opposite or same sex with whom the Subscriber has established an Unregistered Domestic Partnership.

Unregistered Domestic Partnership – A relationship between the Subscriber and one other person of the opposite or same sex. The following requirements apply to both persons:

- They share the same permanent residence and the common necessities of life;
- They are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which they reside;
- Each is at least 18 years of age;
- Each is mentally competent to consent to contract;
- Neither is currently married to another person under either a statutory or common law;
- They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:
    - Have a single dedicated relationship of at least 6 months duration.
    - Joint ownership of residence.
    - At least two of the following:
        - ♦ Joint ownership of an automobile.
        - ♦ Joint checking, bank or investment account.
        - ♦ Joint credit account.
        - ♦ Lease for a residence identifying both partners as tenants.
        - ♦ A will and/or life insurance policies which designates the other as primary beneficiary.
- The Subscriber and Domestic Partner must jointly sign an affidavit of Domestic Partnership.

Section 2: Enrollment and Effective Date of Coverage

Section 2.1 Enrollment

Eligible Persons may enroll themselves and their Dependents for Coverage under the Contract 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 Contract.

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 following the date on which the waiting 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 Contract 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 Contract 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 Contract

The Company may, at any time, discontinue this benefit plan and/or all similar benefit plans for the reasons specified in the Contract. 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 Contract is terminated, as specified in the Contract. The Enrolling Group is responsible for notifying you of the termination of the Contract.

B. The date 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 Contract.

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.

Section 3.2 Extended Coverage for Handicapped Dependent Children

Coverage of an unmarried Enrolled Dependent who is incapable of self-support because of a physically or mentally disabling injury, illness or condition, will be continued beyond the age listed under the definition of Dependent provided that:

A. the Enrolled Dependent is chiefly dependent upon the Subscriber for support and maintenance; and

B. proof of such incapacity and dependence is furnished to the Company within 60 days of the date the Subscriber receives a request for such proof from the Company; and

C. payment of any required Premium for the Enrolled Dependent is continued.

You will be notified 90 days prior to the Enrolled Dependent's attainment of the limiting age.

If the Company fails to make the determination prior to the Enrolled Dependent attaining the limiting age, the Company shall continue coverage of the child pending its receipt of the necessary documentation requested, and until a determination has been made and the member is so advised 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 Contract. The Company may reasonably request information about the Enrolled Dependent's continued incapacity and dependency, but not sooner than two years after attainment of the limiting age and not more frequently than annually after that.

Section 3.3 Services in Progress When Coverage Ends

A Covered Person may have Dental Services already in progress when Coverage under this plan ends. Most services that are started but not completed prior to the date Coverage ends will be completed by the Participating Dentist under the terms of the plan.

Inlays, onlays and fixed bridges are considered started when the tooth or teeth are prepared. Root canal treatment is considered started when the pulp chamber is opened. Dentures are considered started when the impressions are taken. When one of these services is begun before Coverage ends, the Covered Person may have the service completed for the Covered Person Copayment identified in the Schedule of Covered Dental Services.

If comprehensive orthodontic treatment is in progress on the date Coverage ends, the Network orthodontist may prorate his or her usual fee over the remaining months of treatment. The Covered Person is responsible for all payments to the Network orthodontist for services after the termination date.

Section 3.4 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 contract 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 Contract 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 3.5 Reinstatement of the Contract After Termination

If your Coverage is terminated for nonpayment, the Company shall reinstate the Coverage as though it had never been terminated if such payment is received on or before the due date of the succeeding prepaid or periodic payment.

The Company shall not reinstate the Coverage if one of the following exceptions exist:

1. In the notice of termination, the Company notifies you that if payment is not received within 15 days of issuance of the notice of termination, a new application is required and the conditions under which a new Contract will be issued or the original contract reinstated; or

2. If such payment is received more than 15 days after issuance of the notice of termination, the plan refunds such payment within 20 business days; or

3. If such payment is received more than 15 days after issuance of the notice of termination, the plan issues to you, within 20 business days of receipt of such payment, a new Contract accompanied by written notice stating clearly those respects in which the new Contract differs from the cancelled Contract in benefits, coverage or otherwise.

Section 4: Reimbursement

Section 4.1 If You Get A Bill

Your Participating Dentist will bill you for services that are not Covered by this dental plan. If you are billed for a Covered Service by your Participating Dentist, and you feel this billing is in error, you should do the following:

1. Call the Participating Dentist to let them know you believe you have received a bill in error.
2. If you are unable to resolve this issue, please contact our customer service department at the telephone number shown on your ID card.

Should we pay any fees for services that are the responsibility of the Subscriber, the Subscriber shall reimburse us for such payment. Failure to reimburse us or reach reasonable accommodations with us concerning repayment within 30 days after we request for reimbursement shall be grounds for termination of a Subscriber's membership pursuant to *Section 3: Termination of Coverage*. The exercise of our right to terminate the Subscriber shall not affect the plan's right to continue enforcement of its right to reimbursement from the Subscriber.

Section 4.2 Your Billing Protection

All our Subscribers have rights that protect them from being charged for Covered Services in the event we fail to pay a Participating Dentist, a Participating Dentist becomes insolvent, or a Participating Dentist breaches its contract with us. In none of these instances may the Participating Dentist send you a bill, charge you, or have any other recourse against you for a Covered Service. However, this provision does not prohibit the collection of Copayment amounts as outlined in the *Schedule of Covered Dental Services*.

In the event of a Participating Dentist's insolvency, we will continue to arrange for your benefits. If for any reason we are unable to pay for a Covered Service on your behalf (for instance, in the unlikely event of our insolvency or a natural disaster), you are not responsible for paying any bills as long as you received proper authorization from your Participating Dentist. You may, however, be responsible for any properly authorized Covered Services from a Non-Participating Dentist or Emergency services from a Non-Participating Dentist.

NOTE: If you receive a bill because a Non-Participating Dentist refused to accept payment from us, you may submit a claim for reimbursement.

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 Contract, 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 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 your complaint within 30 days of receiving it.

Section 5.2 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.

Section 5.3 Contacting the California Department of Managed Health Care

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the California Department of Managed Health Care for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

Contact information for the California Department of Managed Care:

Toll-free: 1-888-HMO-2219

TDD: 1-888-688-9891

www.hmohelp.ca.gov.

Complaint forms, IMR application forms and instructions are available online from the California Department of Managed Care.

Section 6: General Provisions

Section 6.1 Entire Contract

The Contract issued to the Enrolling Group, including the *EOC(s)*, *Schedule(s) of Covered Dental Services*, the Enrolling Group's application, Amendments and Riders, constitute the entire Contract. 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.

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 Contract after it has been in force for a period of 2 years.

Section 6.4 Amendments and Alterations

Amendments to the Contract 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 Contract 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 Contract or to waive any of its provisions.

Section 6.5 Relationship Between Parties

The relationships between the Company and Participating Dentists and relationships between the Company and Enrolling Groups, are solely contractual relationships between independent contractors. Participating Dentists 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 Participating Dentists or Enrolling Groups.

The relationship between a Participating Dentist and any Covered Person is that of provider and patient. The Participating Dentist 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 Contract. 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 Contract Charge to the Company, and for notifying Covered Persons of the termination of the Contract.

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 Contract. 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 Contract, 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 Contract, 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 Contract, the Company and its related entities may use and transfer the information gathered under the Contract in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your dental records 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 Participating 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 Contract. 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 Contract 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 Contract 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 Contract 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 Contract, *EOC* 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 Contract, *EOC* 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 Contract, *EOC* or *Schedule of Covered Dental Services*.

Section 6.13 Headings

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

Section 6.14 Unenforceable Provisions

If any provision of the Contract, *EOC* 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 Contract, *EOC* 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; medical benefits under group or individual automobile contracts; 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: Individual Continuation of Coverage

Section 8.1 Continuation Coverage

A Covered Person whose Coverage would otherwise end under the Contract may be entitled to elect continuation Coverage in accordance with federal law (under COBRA) and as outlined in *Sections 8.2 through 8.5* below or in accordance with state law and as outlined in *Section 8.6* 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 Contract will terminate as scheduled under the prior plan or in accordance with the terminating events set forth in *Section 8.5* 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 Contract may be entitled to elect continuation Coverage in accordance with federal law, as outlined in *Sections 8.2 through 8.5* below.

Section 8.2 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 8.3 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 8.4 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 8.5 Terminating Events for Continuation Coverage Under Federal Law

Continuation under the Contract 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 8.3*. 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 8.3*. 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 8.3*.

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 Contract 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 8.3*.

G. The date the entire Contract ends.

H. The date Coverage would otherwise terminate under the Contract.

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 8.3* 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 8.3* 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 8.5* 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 8.6 Individual Continuation of Coverage

In the event the Group ceases to exist, the Group contract is terminated, an individual subscriber leaves the Group or the Member's eligibility status changes, the Member may remain in the Plan if he/she otherwise satisfies the eligibility criteria for COBRA or CAL-COBRA.

Member Rights

During the term of the contract between us and your Organization, we guarantee that it will not decrease any benefits, increase any co-payment, or change any exclusion or limitation. We will not cancel or fail to renew your enrollment in this Plan because of your health condition or your requirements for dental care. Your Selected General Dentist is responsible to you for all treatment and services, without interference from us.

However, your Selected General Dentist must follow the rules and limitations set up by us and conduct his or her professional relationship with you within the guidelines established by us. If our relationship with your Selected General Dentist ends, your dentist is obligated to complete any and all treatment in progress. We will arrange a transfer for you to another dentist to provide for continued coverage under the Plan. As indicated on your enrollment form, your signature authorizes us to obtain copies of your dental records, if necessary.

As a member, you have the right to:

- Be treated with respect, dignity and recognition of your need for privacy and confidentiality.
- Express complaints and be informed of the complaint process.
- Have access and availability to care and access to and copies of your dental records.
- Participate in decision-making regarding your course of treatment.
- Be provided information regarding Selected General Dentists.
- Be provided information regarding the services, benefits and specialty referral process.

Member Responsibilities

As a member, you have the responsibility to:

- Identify yourself to your Selected General Dentist as a member. If you fail to do so, you may be charged the dentist's usual and customary fees instead of the applicable co-payment, if any.
- Treat the dentist and his or her office staff with respect and courtesy and cooperate with the prescribed course of treatment. If you continually refuse a prescribed course of treatment, your Selected General Dentist or Specialist has the right to refuse to treat you. We will facilitate second opinions and will permit you to change your Selected General Dentist or Specialist if there is a breakdown in your relationship; however, we will not interfere with the dentist-patient relationship and cannot require a particular dentist to perform particular services.
- Keep scheduled appointments or contact the dental office twenty-four (24) hours in advance to cancel an appointment. If you do not, you may be charged a missed appointment fee.
- Make co-payments at the time of service. If you do not, the dentist may collect those co-payments from you at subsequent appointments and in accordance with their policies and procedures.
- Notify us of changes in family status. If you do not, we will be unable to authorize dental care for you and/or your family members.
- Be aware of and follow your Organization's guidelines in seeking dental care. If you do not, your Organization may not have sufficient information to report your eligibility to us, which could result in a denial of care.

Language Assistance

As a DBP member you have a right to free language assistance services, including oral interpretation and, for some documents, translation services in most frequently spoken languages. DBP collects and maintains your language preferences, race, and ethnicity so that we can communicate more effectively with our members. If you require language assistance or would like to inform DBP of your preferred language, please contact DBP at 1-800-445-9090 or via our online website at www.myuhc.com.

Como miembro de DBP, usted tiene derecho a recibir servicios de ayuda en otros idiomas en forma gratuita, incluyendo interpretación oral y, para ciertos documentos, servicios de traducción en los idiomas que se hablan con más frecuencia. DBP recopila y mantiene sus preferencias de idioma, raza y origen étnico para que podamos comunicarnos con más eficacia con nuestros miembros. Si necesita ayuda en otros idiomas o desea informar a DBP cuál es su idioma preferido, comuníquese con DBP al 1-800-445-9090 o a través de nuestro sitio de Internet en línea en www.myuhc.com.

身為 DBP
會員，您有權利取得免費語言協助服務，包括多數常用語言的口譯服務及部份文件的書面翻譯服務。DBP
查並記錄您的語言偏好、種族與民族，以增進與會員間溝通的效率。若您需要語言協助或希望將您的語言偏好通知 DBP，請致電 (877) 813-4259 與 DBP 聯絡，或至網站 www.myuhc.com.

Non-Covered Services

IMPORTANT: If you opt to receive dental services that are non-covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost each service. If you would like more information about dental coverage options, you may call member services at 1-800-999-3367 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

For purposes of this section, "covered services" or "covered dental services" means dental care services for which the plan is obligated to pay pursuant to an enrollee's plan contract, or for which the plan would be obligated to pay pursuant to an enrollee's plan contract but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations or alternative benefit payments.

Section 9: for Obtaining Benefits

Section 9.1 Dental Services

You are eligible for Coverage for Dental Services listed in the *Schedule of Covered Dental Services* and *Section 10: Covered Dental Services* of this *EOC* 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 Contract.

Subscribers choose a Dentist from a list of Participating Dentists provided by the dental plan. A Covered Person can also call to determine which providers participate in the Network. The telephone number for customer Service is on the ID card.

Within the Service Area, you are entitled to receive all the Dental Services specified in the *Schedule of Covered Dental Services* and *Section 10: Covered Dental Services* of this *EOC*. You must go to your Participating Dentist for these services unless the dental plan has made prior special arrangements for you. If you do not use a Participating Dentist and the dental plan has not approved the use of a Non-Participating Dentist you will not be Covered for any services received.

Enrolling for Coverage under the Contract does not guarantee Dental Services by a particular Participating Dentist on the list of providers. The list of Participating Dentists is subject to change. When a provider on the list no longer has a contract with the Company, you must choose among remaining Participating 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 may be denied.

Coverage for Dental Services is subject to payment of the Premium required for Coverage under the Contract and payment of the Copayment specified for any service shown in the *Schedule of Covered Dental Services* and *Section 10: Covered Dental Services*.

Participating 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 Participating Dentist bills a Covered Person, customer service should be called. A Covered Person does not need to submit claims for Participating Dentist services or supplies.

Prohibited Referral

The Dental Plan will not make payment of any claim, bill, or other demand or request for payment for dental care services that the appropriate regulatory board determines were provided as a result of a "prohibited referral." Prohibited referral means any referral from a Participating Dentist in which the Participating Dentist owns a beneficial interest; or, in which the Participating Dentist's immediate family owns a beneficial interest of three percent (3%) or greater; or, with which the Participating Dentist, his/her immediate family, or the Participating Dentist in combination with his/her immediate family has a compensation arrangement.

Section 9.2 Selecting a Participating Dentist

This plan is designed to provide quality dental care while controlling the cost of this care. Covered Persons must seek Dental Services from a Participating Dentist. Except for Emergency Dental Services, in no event will we cover Dental Services provided to a Covered Person by a Non-Participating Dentist. The Network includes Participating Dentists in a Covered Person's geographic area. A "Participating Dentist" is a Dentist that has a provider agreement in force with us. When a Covered Person enrolls in

this plan, he or she will get information about our current Participating Dentists. If you have any further questions regarding provider location, office hours or emergency hours or other providers in your area, or to request a copy of the provider directory, you may contact customer service at the telephone number on your ID card to receive that information. You can also find an online version of the directory at www.myuhc.com.

After enrollment, a Covered Person will receive an ID card. A Covered Person can schedule an appointment by simply calling the Dentist and must present this ID card when he or she goes to his or her Participating Dentist. Please read your materials carefully for specific benefit levels, exclusions, Coverage limits and Covered Person Copayments. You can call our customer service department at the telephone number on your ID card if you have any questions after reading your materials.

Section 9.3 Emergency Dental Services

All Participating Dentists provide Emergency Dental Services twenty-four (24) hours a day, seven (7) days a week. You should contact your Participating Dentist, who will make arrangements for Emergency care. If you are unable to reach your Participating Dentist in an Emergency during normal business hours, you must call our customer service department for instructions.

If you are unable to reach your Participating Dentist in an Emergency after normal business hours, you may seek Emergency Dental Services from any licensed Dentist. Then, within 2 business days, you should call our customer service department to notify us of the Emergency claim.

Claims for Emergency Dental Services

To receive reimbursement, you do not have to submit a claim form. All you have to do is send us, within 90 days, the itemized bill, marked "PAID," along with a brief explanation of why the Emergency Dental Services were Necessary. We will provide reimbursement within 30 days of receipt. We will reimburse you for the cost of the Emergency Dental Services, less any Copayment which may apply.

All reimbursement requests should be mailed to:

Dental Benefit Providers of California, Inc.

P.O. Box 30567

Salt Lake City, Utah 84130-0567

Section 9.4 Specialty Referrals

Your Participating Dentist is responsible for providing all Covered Dental Services. But, certain services may be eligible for referral to a Network Specialist Dentist. Specialty care will be Covered, less any applicable Copayment, when such specialty services are provided in accordance with the specialty referral process described below.

All Specialty Referral Services Must Be: (A) Pre-Authorized by us; and (B) Coordinated by a Covered Person's Participating Dentist. Any Covered Person who elects specialist care without prior referral by his or her Participating Dentist and approval by us is responsible for all charges incurred.

In order for specialty services to be Covered by this plan, the following referral process must be followed:

1. A Covered Person's Participating Dentist must coordinate all Dental Services.
2. When the care of a Network Specialist Dentist is required, the Covered Person's Participating Dentist must contact us and request authorization.

3. If the Participating Dentist's request for specialist referral is approved, we will notify the Covered Person. He or she will be instructed to contact the Network Specialist Dentist to schedule an appointment.

4. If the Participating Dentist's request for specialist referral is denied, the Participating Dentist and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the Participating Dentist may be asked to perform the service.

5. A Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not pre-authorized by us to provide such services.

Except for pediatric specialty services, when specialty services are provided the Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's *Schedule of Covered Dental Services*.

Section 9.5 Pediatric Specialty Services

During a Participating Dentist visit, a Covered Person under age 6 may be unmanageable. In such case, the Covered Person may be referred to a Network pediatric Specialist Dentist for the current treatment plan only. Following completion of that authorized pediatric treatment plan, the Covered Person must return to the Participating Dentist for further services. Subsequent referrals to the Network pediatric Specialist Dentist, if any, must first be authorized by us. Any services performed by a pediatric Specialist Dentist after the Covered Person's 6th birthday will not be Covered.

Section 9.6 Second Opinion Consultation

A Covered Person, or his or her treating Participating Dentist, may submit a request for a second dental opinion to us by writing or calling our customer service department at the telephone number on your ID card. Referrals to a Provider for second dental opinions will be provided when requested. All requests for a second opinion are processed within five (5) business days of receipt by us of such request. The requesting Participating Dentist will be notified both verbally and in writing within 24 hours of the decision. The decision will be communicated to a requesting Covered Person verbally (when possible) and in writing within 2 business days.

Second dental opinions will be rendered by an appropriately qualified dental professional. An appropriately qualified dental professional is a licensed health care dental Provider who is acting within his or her scope of practice and who possesses the clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second dental opinion.

If the Covered Person is requesting a second dental opinion about care received from his or her Participating Dentist, the second dental opinion will be provided by an appropriately qualified health care professional within the Network. If the Covered Person is requesting a second dental opinion about care received from a Specialist Dentist, the second dental opinion will be provided by a Specialist within the Network of the same or equivalent specialty.

Section 10: Covered Dental Services

Dental Services described in this Section and in the *Schedule of Covered Dental Services* are Covered when such services are Necessary and not excluded as described in *Section 11: General Exclusions*.

Covered Dental Services are subject to satisfaction of the payment of any Copayments as described below and in the *Schedule of Covered Dental Services*.

Covered Dental Services must be provided by or directed by a Participating Dentist.

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 for each Covered Dental Service; and (3) describe any Maximum Benefits that may apply.

Section 10.1 Additional Provisions

Multiple Crown/Bridge Unit Treatment Fee

A Covered Person's recommended treatment plan may include 7 or more Covered units of crown and/or bridge to restore teeth or replace missing teeth. In such case, the Covered Person must pay both: (a) the usual crown or bridge patient charge for each unit of crown or bridge; and (b) an additional charge per unit. These charges are shown in the Schedule of Covered Dental Services. The maximum benefit within a 12-month period is for 7 crowns or pontics.

Noble and High Noble Metals

The plan provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal is used, the Covered Person must pay: (a) the Copayment for the inlay, onlay, crown or fixed bridge; and (b) an added charge equal to the actual laboratory cost of the high noble metal not to exceed $150.

Section 11: General Exclusions

Section 11.1 Exclusions

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

A. Dental Services that are not Necessary.

B. Costs for non-Dental Services related to the provision of Dental Services in hospitals, extended care facilities, or Subscriber's home. When deemed Necessary by the Participating Dentist, the Subscriber's Physician and authorized by us, Covered Dental Services that are delivered in an inpatient or outpatient hospital setting are Covered as indicated in the Schedule of Covered Dental Services.

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 participating dental setting. This will not apply to Covered Emergency Dental Services.

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. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

I. 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.

J. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

K. 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.

L. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), 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.

M. 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.

N. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Contract.

O. Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.

P. 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.

Q. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

R. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

S. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

T. Services rendered by a provider who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.

U. Dental Services otherwise Covered under the Contract, but rendered after the date individual Coverage under the Contract terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Contract terminates.

V. Foreign Services are not Covered unless required as an Emergency.

W. 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.

X. Any Dental Services or Procedures not listed in the *Schedule of Covered Dental Services*.

Y. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.

Z. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the Participating Dentist; or (b) treatment by a specialist without referral from the Participating Dentist and our approval.

AA. Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.

BB. Treatment which requires the services of a pediatric specialist, after the Covered Person's 6th birthday.

CC. Consultations for non-Covered services.

DD. A service started but not completed prior to the Covered Person's eligibility to receive benefits under the plan. Inlays, onlays and fixed bridges are considered started when the tooth or teeth are prepared. Root canal treatment is considered started when the pulp chamber is opened. Orthodontics are considered started at the time of initial banding. Dentures are considered started when the impressions are taken.

EE. A service started (as defined above) by a Non-Participating Dentist. This will not apply to Covered Emergency Dental Services.

FF. Procedures performed to facilitate non-Covered services, including but not limited to: (a) root canal therapy to facilitate either hemisection or root amputation; and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.

GG. Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.

HH. Relative analgesia (N2O2- nitrous oxide).

Section 11.2 Orthodontic Exclusions and Limitations

If you require the services of an orthodontist, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatment, the Covered Person will be responsible for all costs associated with any orthodontic treatment. Orthodontic services Copayments are valid for authorized services rendered by a Network orthodontist.

If you terminate Coverage after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

A. The following are not Covered orthodontic benefits:

- Treatment in progress prior to the effective date of this Coverage
- Extractions required for orthodontic purposes
- Surgical orthodontics or jaw repositioning
- Myofunctional therapy
- Cleft palate
- Micrognathia
- Macroglossia
- Hormonal imbalances
- Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of accident
- Palatal expansion appliances
- Services performed by outside laboratories
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person

B. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.

C. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.

D. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a $50 consultation fee, plus any lab costs incurred by the orthodontist.

E. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is

obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.

UnitedHealthcare®

dental plan

Direct Compensation (DC) Contributory CA240/covered dental services

CA D1094

ADA	DESCRIPTION	MEMBER PAYS
DIAGNOSTIC SERVICES		
D0120	PERIODIC ORAL EVALUATION EST PT	$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	$0
D0145	ORAL EVAL PT<3 AND COUNSEL	$0
D0150	COMP ORAL EVALUATION - NEW/EST PT	$0
D0160	DTL&EXT ORAL EVAL - PROB FOCUS RPT	$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	$0
D0171	RE-EVALUATION – POST-OPERATIVE OFFICE VISIT	$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	$0
D0190	SCREENING OF A PATIENT	$5
D0191	ASSESMENT OF A PATIENT	$5
D0210	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES	$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$0
D0230	INTRAORL PERIAPICAL EA ADD RADIOGRAPHIC IMAGE	$0
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	$0
D0251	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	$0
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	$0
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	$0
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$0
D0290	POSTERIOR-ANTERIOR OR LATERAL SKULL AND FACIAL SURVEY RADIOGRAPHIC IMAGE	$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	$10
D0364	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$10
D0365	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$10
D0366	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$15
D0367	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS	$15
D0368	CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$20
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	$5
D0414	LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	$0
D0415	COLLECT MICROORAGNISMS CULT & SENS	$0
D0416	VIRAL CULTURE	$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	$0
D0418	ANALYSIS OF SALIVA SAMPLE	$0
D0425	CARIES SUSCEPTIBILITY TESTS	$0
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	$0
D0460	PULP VITALITY TESTS	$0
D0470	DIAGNOSTIC CASTS	$0
D0472	ACCESS TISS-GROSS EXAM-PREP & REPRT	$0
D0473	ACCESS TISS-GROSS/MICRO-PREP/REPRT	$0
D0474	ACSS TISS GR&MIC SURG MARG PREP/RPT	$0
D0601	CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	$0
D0602	CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	$0
D0603	CARIES RISK ASSESSMENT AND DOCUMENTATION, HIGH	$0
PREVENTIVE SERVICES		
D1110	PROPHYLAXIS - ADULT	$0

ADA	DESCRIPTION	MEMBER PAYS
D1120	PROPHYLAXIS - CHILD	$0
D1206	TOP FLUORIDE VARNISH	$0
D1208	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	$0
D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	$0
D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	$0
D1330	ORAL HYGIENE INSTRUCTIONS	$0
D1351	SEALANT - PER TOOTH	$0
D1352	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	$0
D1353	SEALANT REPAIR – PER TOOTH	$0
D1510	SPACE MAINTAINER - FIXED-UNILATERAL	$0
D1516	SPACE MAINTAINER - FIXED-BILATERAL, MAXILLARY	$0
D1517	SPACE MAINTAINER - FIXED-BILATERAL, MANDIBULAR	$0
D1520	SPACE MAINTAINER - REMOVABLE-UNI	$0
D1526	SPACE MAINTAINER - REMOVABLE-BILATERAL, MAXILLARY	$0
D1527	SPACE MAINTAINER - REMOVABLE-BILATERAL, MANDIBULAR	
D1550	RECEMENT OR RE-BOND SPACE MAINTAINER	$0
D1555	REMOVAL OF FIXED SPACE MAINTAINER	$0
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED – UNILATERAL	$0
RESTORATIVE SERVICES		
D2140	AMALGAM-ONE SURFACE PRIMARY/PERM	$5
D2150	AMALGAM-TWO SURFACES PRIMARY/PERM	$5
D2160	AMALGAM-3 SURFACES PRIMARY/PERM	$10
D2161	AMALGAM-FOUR/MORE SURF PRIM/PERM	$10
D2330	RESIN COMPOS - ONE SURFACE ANTERIOR	$5
D2331	RESIN COMPOS - 2 SURFACES ANTERIOR	$5
D2332	RESIN COMPOS - 3 SURFACES ANTERIOR	$10
D2335	RSN COMPOS-4/> SURF/W/INCISAL ANG	$10
D2390	RESIN COMPOS CROWN ANTERIOR	$20
D2391	RESIN COMPOS - 1 SURFACE POSTERIOR	$5
D2392	RESIN COMPOS - 2 SURFACES POSTERIOR	$10
D2393	RESIN COMPOS - 3 SURFACES POSTERIOR	$10
D2394	RESIN COMPOS - 4/MORE SURFACES POST	$10
D2510	INLAY - METALLIC - ONE SURFACE	$95
D2520	INLAY - METALLIC - TWO SURFACES	$95
D2530	INLAY - METALLIC - 3/MORE SURFACES	$95
D2542	ONLAY - METALLIC - TWO SURFACES	$95
D2543	ONLAY METALLIC THREE SURFACES	$95
D2544	ONLAY METALLIC FOUR OR MORE SURF	$95
D2610	INLAY - PORCELN/CERAMIC - 1 SURFACE	$35
D2620	INLAY - PORCELN/CERAMIC - 2 SURF	$40
D2630	INLAY - PORCELN/CERAM - 3/MORE SURF	$45
D2642	ONLAY - PORCELN/CERAMIC - 2 SURF	$95
D2643	ONLAY - PORCELN/CERAMIC - 3 SURF	$95
D2644	ONLAY - PORCELN/CERAM - 4/MORE SURF	$95
D2650	INLAY-RSN COMPOS COMPOS/RSN-1 SURF	$30
D2651	INLAY-RSN COMPOS COMPOS/RSN-2 SURF	$35
D2652	INLAY-RSN COMPOS COMPOS/RSN-3/>SURF	$40
D2662	ONLAY-RSN COMPOS COMPOS/RSN-2 SURF	$30
D2663	ONLAY-RSN COMPOS COMPOS/RSN-3 SURF	$40
D2664	ONLAY-RSN COMPOS COMPOS/RSN-4/>	$45
D2710	CROWN RESINBASED COMPOSITE INDIRECT	$20
D2712	CROWN 3/4 RESNBASED COMPOS INDIRECT	$20
D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	$40
D2721	CROWN - RESIN W/PREDOM BASE METAL	$30
D2722*	CROWN - RESIN WITH NOBLE METAL	$30
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$100
D2750*	CROWN - PORCELN FUSED HI NOBLE METL	$100
D2751	CROWN-PORCELN FUSD PREDOM BASE METL	$90

ADA	DESCRIPTION	MEMBER PAYS
D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	$100
D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	$95
D2781	CROWN - 3/4 CAST PREDOM BASE METL	$90
D2782*	CROWN - 3/4 CAST NOBLE METAL	$95
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$95
D2790*	CROWN - FULL CAST HIGH NOBLE METAL	$100
D2791	CROWN - FULL CAST PREDOM BASE METL	$90
D2792*	CROWN - FULL CAST NOBLE METAL	$100
D2794*	CROWN TITANIUM	$100
D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	$5
D2915	RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFAB POST & CORE	$5
D2920	RECEMENT OR RE-BOND CROWN	$5
D2921	REATTACHMENT OF TOOTH FRAGMENT	$5
D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	$10
D2930	PRFABR STAINLESS STEEL CROWN-PRIM	$10
D2931	PRFABR STAINLESS STEEL CROWN-PERM	$10
D2932	PREFABRICATED RESIN CROWN	$10
D2933	PRFABR STNLSS STEEL CROWN RSN WNDOW	$10
D2934	PREFAB ESTHTC COATED STNLESS STEEL CROWN - PRIMARY	$10
D2940	SEDATIVE FILLING	$5
D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$5
D2950	CORE BUILDUP INCLUDING ANY PINS	$5
D2951	PIN RETN - PER TOOTH ADDITION REST	$5
D2952	POST & CORE ADD CROWN INDIRECT FAB	$25
D2953	EA ADD INDIRECT FAB POST SAME TOOTH	$5
D2954	PREFABR POST&CORE ADDITION CROWN	$10
D2955	POST REMOVAL	$20
D2957	EA ADD PREFABR POST - SAME TOOTH	$5
D2960	LABIAL VENEER (LAMINATE) - CHAIRSIDE	$20
D2961	LABIAL VENEER (RESIN LAMINATE) - LABORATORY	$40
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY	$40
D2971	ADD PROC NEW CROWN XST PART DENTURE	$10
D2975	COPING	$70
D2980	CROWN REPAIR	$15
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	$10
ENDODONTIC SERVICES		
D3110	PULP CAP - DIRECT	$0
D3120	PULP CAP - INDIRECT	$0
D3220	TX PULPOT-CORONL DENTNOCEMENTL JUNC	$0
D3221	PULPAL DEBRID PRIMARY&PERM TEETH	$5
D3222	PARTIAL PULPOTOMY	$0
D3230	PULPAL THERAPY - ANT PRIMARY TOOTH	$0
D3240	PULPAL THERAPY - POST PRIMARY TOOTH	$0
D3310	ANTERIOR	$15
D3320	BICUSPID	$20
D3330	MOLAR	$60
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	$5
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	$0
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	$5
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	$15
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	$20
D3348	RETX PREVIOUS RC THERAPY - MOLAR	$35
D3351	APEXIFICAT/RECALCIFICAT - INIT VST	$5
D3352	APEXIFICAT/RECALCIFICAT-INTERIM	$5
D3353	APEXIFICAT/RECALCIFICAT-FINAL VISIT	$10
D3355	PULPAL REGENERATION - INITIAL VISIT	$5
D3356	PULPAL REGENERATION -INTERIM MEDICAMENT REPLACEMENT	$5
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT	$10

ADA	DESCRIPTION	MEMBER PAYS
D3410	APICOECTOMY SURG - ANT	$15
D3421	APICOECTOMY SURG-BICUSPID	$20
D3425	APICOECTOMY SURG - MOLAR	$30
D3426	APICOECTOMY SURGERY	$10
D3427	PERIRADICULAR SURGERY WITHOUT APICOECTOMY	$13
D3430	RETROGRADE FILLING - PER ROOT	$10
D3450	ROOT AMPUTATION - PER ROOT	$12
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$1,950
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	$5
D3920	HEMISECTION NOT INCL RC THERAPY	$5
D3950	CANAL PREP&FIT PREFORMED DOWEL/POST	$5
PERIODONTIC SERVICES		
D4210	GINGIVECT/PLSTY 4/>CNTIG TEETH QUAD	$10
D4211	GINGIVECT/PLSTY 1-3CNTIG TEETH QUAD	$5
D4212	GINGIVECT/PLSTY WITH REST PROC/TOOTH	$0
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$10
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$5
D4245	APICALLY POSITIONED FLAP	$10
D4249	CLIN CROWN LEN - HARD TISSUE	$10
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$30
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$20
D4263	BONE REPLCMT GRAFT - 1 SITE QUAD	$15
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$10
D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	$10
D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH	$15
D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD TOOTH	$5
D4320	PROVISIONAL SPLINTING - INTRACORONAL	$10
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	$5
D4341	PRDNTL SCAL&ROOT PLAN 4/>TEETH-QUAD	$5
D4342	PRDONTAL SCAL&ROOT PLAN 1-3 TEETH	$5
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	$0
D4355	FULL MOUTH DEBRID COMP EVAL&DX	$5
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$5
D4910	PERIODONTAL MAINTENANCE	$0
D4920	UNSCHEDULED DRESSING CHANGE	$0
D4921	GINGIVAL IRRIGATION - PER QUADRANT	$0
REMOVABLE PROSTHODONTIC SERVICES		
D5110	COMPLETE DENTURE - MAXILLARY	$140
D5120	COMPLETE DENTURE - MANDIBULAR	$140
D5130	IMMEDIATE DENTURE - MAXILLARY	$140
D5140	IMMEDIATE DENTURE - MANDIBULAR	$140
D5211	MAX PARTIAL DENTURE - RESIN BASE	$40
D5212	MAND PARTIAL DENTUR - RESIN BASE	$40
D5213	MAX PART DENTUR-CAST METL W/RSN	$140
D5214	MAND PART DENTUR- CAST METL W/RSN	$140
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$30
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$30
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$30
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$30

ADA	DESCRIPTION	MEMBER PAYS
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	$40
D5226	MANDIBULAR PART DENTURE FLEX BASE	$40
D5282	REMV UNI PART DENTUR-1 PC CAST METL - MAXILLARY	$20
D5283	REMV UNI PART DENTUR-1 PC CAST METL - MANDIBULAR	$20
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$5
D5411	ADJUST COMPLETE DENTUR - MANDIBULAR	$5
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$5
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$5
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	$10
D5512	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	$10
D5520	REPL MISS/BROKEN TEETH-CMPL DENTUR	$5
D5611	REPAIR RESIN PARTIAL DENTURE BASE - MANDIBULAR	$10
D5612	REPAIR RESIN PARTIAL DENTURE BASE - MAXILLARY	$10
D5621	REPAIR CAST PARTIAL FRAMEWORK - MANDIBULAR	$25
D5622	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	$25
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	$25
D5640	REPLACE BROKEN TEETH - PER TOOTH	$10
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	$10
D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	$20
D5670	REPL ALL TEETH&ACRYLC FRMEWRK MAX	$45
D5671	REPL ALL TEETH&ACRYLC FRMEWRK MAND	$45
D5710	REBASE COMPLETE MAXILLARY DENTURE	$40
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$40
D5720	REBASE MAXILLARY PARTIAL DENTURE	$30
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$30
D5730	RELINE CMPL MAXIL DENTURE CHAIRSIDE	$25
D5731	RELINE CMPL MAND DENTURE CHAIRSIDE	$25
D5740	RELINE MAXIL PART DENTURE CHAIRSIDE	$20
D5741	RELINE MAND PART DENTURE CHAIRSIDE	$20
D5750	RELINE CMPL MAXIL DENTURE LAB	$30
D5751	RELINE CMPL MAND DENTRUE LABORATORY	$30
D5760	RELINE MAXIL PART DENTURE LAB	$30
D5761	RELINE MAND PART DENTURE LABORATORY	$30
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	$40
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	$40
D5820	INTERIM PARTIAL DENTURE MAXILLARY	$30
D5821	INTERIM PARTIAL DENTURE MANDIBULAR	$30
D5850	TISSUE CONDITIONING MAXILLARY	$5
D5851	TISSUE CONDITIONING MANDIBULAR	$5
D5863	OVERDENTURE - COMPLETE MAXILLARY	$140
D5864	OVERDENTURE - COMPLETE MANDIBULAR	$140
D5865	OVERDENTURE - PARTIAL MAXILLARY	$140
D5866	OVERDENTURE - PARTIAL MANDIBULAR	$140
D5876	ADD MENTAL SUBSTRUCTURE TO ACRYLIC FULL DENTURE, PER ARCH	$40
IMPLANT SERVICES		
D6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$1,950
D6011	SECOND STAGE IMPLANT SURGERY	$1,950
D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	$1,950
D6052	SEMI-PRECISION ATTACHMENT ABUTMENT	$368
D6055	DENTAL IMPLANT SUPPORTED CONNECTING BAR	$540
D6056	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	$368
D6057	CUSTOM FAB ABUTMENT - INCLUDES PLACEMENT	$610
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,050
D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	$915
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	$1,050
D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE	$946

ADA	DESCRIPTION	MEMBER PAYS
	METAL)	
D6062*	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$981
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL)	$854
D6064*	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	$1,168
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,144
D6066*	IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN	$1,083
D6067*	IMPLANT SUPPORTED METAL CROWN	$962
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	$1,026
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	$1,050
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	$965
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	$984
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	$997
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	$910
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	$967
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$1,018
D6076*	IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD	$992
D6077*	IMPLANT SUPPORTED RETAINER FOR CASE METAL FPD	$962
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS	$55
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE	$15
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	$135
D6091	REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT(MALE OR FEMALE COMPONENT) OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS	$410
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	$79
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	$124
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	$810
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	$55
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	$20
D6100	IMPLANT REMOVAL, BY REPORT	$600
D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	$15
D6102	DEBRIDEMENT & OSSEOUS PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	$50
D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT DEFECT	$350
D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$1,840
D6111	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$1,840
D6112	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$1,840
D6113	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$1,840
D6118	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	$40
D6119	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$40
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	$265
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM	$835
FIXED PROSTHODONTIC SERVICES		
D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	$20
D6210*	PONTIC - CAST HIGH NOBLE METAL	$80
D6211	PONTIC - CAST PREDOM BASE METAL	$75
D6212*	PONTIC - CAST NOBLE METAL	$80

ADA	DESCRIPTION	MEMBER PAYS
D6214*	PONTIC TITANIUM	$80
D6240*	PONTIC-PORCELN FUSED HI NOBLE METL	$80
D6241	PONTIC-PORCLN FUSD PREDOM BASE METL	$75
D6242*	PONTIC - PORCELN FUSED NOBLE METAL	$80
D6245	PONTIC - PORCELAIN/CERAMIC	$95
D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	$25
D6251	PONTIC RESIN W/PREDOM BASE METAL	$15
D6252*	PONTIC RESIN W/NOBLE METAL	$15
D6253	PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$25
D6545	RETAINER- CASE MTL FOR RESIN FXD PROS	$10
D6548	RET-PORC/CER FOR RESIN BONDED FIXED PROS	$10
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	$10
D6600	RETAINER INLAY-PORCELAIN/CERAMIC 2 SURFACES	$40
D6601	RETAINER INLAY - PORCELN/CERAMIC 3/MORE SURF	$45
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURF	$40
D6603*	RETAINER INLAY-CAST HI NOBLE METL 3/> SURF	$45
D6604	RETAINER INLAY-CAST PREDOM BASE METL 2 SURF	$40
D6605	RETAINER INLAY-CAST PREDOM BASE METL 3/>SURF	$45
D6606*	RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	$40
D6607*	RETAINER INLAY - CAST NOBLE METL 3/MORE SURF	$45
D6608	RETAINER ONLAY - PORCELN/CERAMIC 2 SURFACES	$45
D6609	RETAINER ONLAY - PORCELN/CERAMIC 3/MORE SURF	$50
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURF	$55
D6611*	RETAINER ONLAY-CAST HI NOBLE METL 3/> SURF	$60
D6612	RETAINER ONLAY-CAST PREDOM BASE METL 2 SURF	$50
D6613	RETAINER ONLAY-CAST PREDOM BASE METL 3/>SURF	$55
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	$50
D6615*	RETAINER ONLAY - CAST NOBLE METL 3/MORE SURF	$50
D6624*	RETAINER INLAY - TITANIUM	$45
D6634*	RETAINER ONLAY - TITANIUM	$75
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$20
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$40
D6721	RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	$30
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	$30
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	$100
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$100
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$90
D6752*	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$100
D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$95
D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$90
D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	$95
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$95
D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$100
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	$90
D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	$100
D6794*	RETAINER CROWN - TITANIUM	$100
D6920	CONNECTOR BAR	$70
D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	$5
D6940	STRESS BREAKER	$5
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	$20
ORAL SURGERY SERVICES		
D7111	XTRCT CORONL RMNNTS DECIDUOUS TOOTH	$5
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$5
D7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$5
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	$10
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	$20

ADA	DESCRIPTION	MEMBER PAYS
D7240	REMOVAL IMPACTED TOOTH - CMPL BONY	$15
D7241	REMV IMP TOOTH-CMPL BNY W/SURG COMP	$25
D7250	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$5
D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL	$5
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$10
D7270	TOOTH REIMPL&/STBL ACC DISPLCD	$10
D7280	SURGICAL ACCESS AN UNERUPTED TOOTH	$10
D7282	MOBILZ ERUPT/MALPSTN TOOTH AID ERUP	$5
D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	$5
D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	$5
D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$5
D7288	BRUSH BIOPSY	$5
D7290	SURGICAL REPOSITIONING OF TEETH	$10
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$5
D7311	ALVEOLOPLSTY CONJNC XTRCT 1-3 TEETH	$5
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$10
D7321	ALVEOLOPLSTY NOT W/XTRCT 1-3 TEETH	$5
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$20
D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	$30
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$20
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$30
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$20
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$30
D7471	REMOVAL OF LATERAL EXOSTOSIS	$15
D7472	REMOVAL OF TORUS PALATINUS	$30
D7473	REMOVAL OF TORUS MANDIBULARIS	$15
D7485	SURGICAL RDUC OSSEOUS TUBEROSITY	$25
D7510	I&D ABSCESS-INTRAORAL SOFT TISS	$5
D7511	I & D ABSC INTRAORAL SOFT TISS COMP	$5
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	$10
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	$10
D7530	REMO OF FORREIGN BODY - SKIN SUBCUTANEOUS	$5
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	$0
D7960	FRENULECTOMY SEPARATE PROCEDURE	$5
D7963	FRENULOPLASTY	$5
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	$10
D7971	EXCISION OF PERICORONAL GINGIVA	$10
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	$20
ADJUNCTIVE GENERAL SERVICES		
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	$5
D9120	FIXED PARTIAL DENTURE SECTIONING	$15
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	$0
D9211	REGIONAL BLOCK ANESTHESIA	$0
D9212	TRIGEMINAL DIVISION BLOCK ANES	$0
D9215	LOCAL ANESTHESIA	$0
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA	$0
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	$5
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	$5
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	$5
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	$5
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	$5

ADA	DESCRIPTION	MEMBER PAYS
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	$5
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	$0
D9430	OV OBS - NO OTH SERVICES PERFORMED	$0
D9440	OV-AFTER REGULARLY SCHEDULED HRS	$5
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	$0
D9943	OCCLUSAL GUARD ADJUSTMENT	$5
D9944	OCCLUSAL GUARD – HARD APPLIANCE, FULL ARCH	$15
D9945	OCCLUSAL GUARD – SOFT APPLIACNE, FULL ARCH	$15
D9946	OCCLUSAL GUARD – HARD APPLIANCE, PARTIAL ARCH	$15
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$5
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$5
D9971	ODONTOPLASTY	$0
D9972	EXTERNAL BLEACHING - PER ARCH PERFORMED IN OFFICE	$125
D9995	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO DENTIST FOR SUBSEQUENT REVIEW	$0
D9996	BROKEN APPOINTMENT	$0
ORTHODONTIC SERVICES		
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION)	$1,500
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	$1,500
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	$1,500
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	$0
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINERS)	$150
D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF TREATMENT	$75
D8999	a START-UP FEE (INCLUDING EXAM, BEGINNING RECORDS, X-RAYS,TRACING, PHOTOS, AND MODELS)	$350
Fixed Prosthedontics		
D5992	ADJUST MAXILLOFACIAL PROSTHETIC APPLIANCE, BY REPORT	$5

*If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed $150 per unit. If a base metal is used, there are no additional charges from the provider.

UnitedHealthcare/Select Managed Care dental exclusions and limitations

LIMITATIONS OF BENEFITS

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1. DENTAL PROPHYLAXIS	Limited to 1 time per 6 months
2. FLUORIDE TREATMENTS	Limited to 1 time per 6 months
3. INLAYS, ONLAYS, AND VENEERS	Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filing cannot restore the tooth.
4. CROWNS	Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filing cannot restore the tooth.
5. POST AND CORES	Covered only for teeth that have had root canal therapy.
6. SCALING AND ROOT PLANING	Limited to 4 quadrants per calendar year.
7. REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS AND IMPLANTS, IMPLANT CROWNS, IMPLANT PROTHESIS	Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays, onlays, and implants, implant crowns, implant prosthesis previously submitted for payment under the plan is limited to 1 time per tooth per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances. 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.
8. INTRAORAL BITEWING RADIOGRAPHS	Limited to 1 series of 4 films in any 6 month period
9. STAINLESS STEEL CROWNS	Limited to 1 time per tooth per 60 Months. Covered only when a filing cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.
10. ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS	Limited to repairs or adjustments performed more than 6 months after the initial insertion.
11. INTRAVENOUS SEDATION OR GENERAL ANESTHESIA	Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions).
12. ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and (B) Coordinated by a Covered Person's Participating Dentist. Any Covered Person who elects specialist care without prior referral by his or her Participating Dentist and approval by us is responsible for all charges incurred. • In order for specialty services to be Covered by this plan, the following referral process must be followed: • A Covered Person's Participating Dentist must coordinate all Dental Services. • When the care of a Network Specialist Dentist is required, the Covered Person's Participating Dentist must contact us and request authorization. • If the Participating Dentist request for specialist referral is denied, the Participating Dentist and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the Participating Dentist may be asked to perform the service. • Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services. • Covered Person's fi nancial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.
13. PERIODONTAL MAINTENANCE PROCEDURES	Limited to once every 6 months, following active therapy, exclusive of gross debridement
14. REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS (MINOR 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 5 years from initial or supplemental placement
15. CROWNS, FIXED BRIDGES, AND IMPLANTS	The maximum benefit within a 12-month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than 7 crowns and/or pontics are done for a Member within a 12-month period, the dentist's fee for any additional crowns within that period would not be limited to the listed Copayment, but instead can reflect the Dentist's Billed Changes.
16. ADJUNCTIVE	Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesion, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
17. INTRAORAL	Complete Series (including bitewings) - Limited to 1 time in any 2-year period
18. TEMPORARY CROWNS	Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filing cannot restore the tooth.
19. CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1.	Dental Services that are not Necessary.
2.	Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.
3.	Any Dental Procedure not directly associated with dental disease.

EXCLUSIONS OF BENEFITS

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

4.	Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
5.	Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
6.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
7.	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.
8.	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.
9.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
10.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
11.	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.
12.	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.
13.	Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
14.	Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities, or Member's home are not covered. When deemed necessary by the Primary Care Dentist, the Member's physician, and authorized by the Plan, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the Schedule of Benefits.
15.	Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
16.	Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
17.	Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by a Participating Dentist; or (b) treatment by a specialist without referral from a Participating Dentist and our approval.
18.	Any Dental Procedure not performed in a dental setting. This will not apply to Covered Emergency Dental Services.
19.	Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.
20.	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
21.	Treatment which requires the services of a pediatric specialist, after the Covered Person's 6th birthday.
22.	Orthodontic Exclusions & Limitations If you require the services of an orthodontist, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatment, the Covered Person will be responsible for all costs associated with any orthodontic treatment. Orthodontic services Copayments are valid for authorized services rendered. If you terminate Coverage after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment. Orthodontic Exclusions: a) Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person b) Treatment in progress prior to the effective date of this coverage c) Extractions required for orthodontic purposes d) Surgical orthodontics or jaw repositioning e) Myofunctional therapy f) Cleft palate g) Micrognathia h) Macroglossia i) Hormonal imbalances j) Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of treatment of accident k) Palatal expansion appliances l) Services performed by outside laboratories Orthodontic Limitations: 1. If a treatment plan is for less than 24 months, then a prorated portion of the full copayment shall apply. 2. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist. 3. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a $50 consultation fee, plus any lab costs incurred by the orthodontist. 4. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this Comprehensive Orthodontic Treatment. If comprehensive treatment is necessary, and is completed within a 24 month period, the Copayments listed will apply. If necessary and active treatment extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.

Contract Amendment

Dental Benefit Providers of California, Inc.

As described in this Amendment, the Contract is modified to include the Timely Access to Care provision.

Covered health care services are provided and arranged in a timely manner appropriate for the nature of the Covered Person's condition consistent with good professional practice. Provider Networks, policies, procedures and quality assurance monitoring systems and processes are established and maintained to ensure compliance with clinical appropriateness standards.

All network and provider processes necessary to obtain covered dental care services, including but not limited to prior authorization processes, are completed in a manner that assures covered dental care services are provided to Covered Persons in a timely manner appropriate for the Covered Person's condition.

When it is necessary for a provider or a Covered Person to reschedule an appointment, the appointment will be promptly rescheduled in a manner that is:

i) Appropriate for the Covered Person's health care needs,

ii) Ensures continuity of care consistent with good professional practices; and

iii) Meets the California standards regarding the accessibility of provider services in a timely manner.

Interpreter services are coordinated with scheduled appointments for health care services in a manner that ensures interpreter services are provided at the time of the appointment, consistent with California standards without imposing an undue delay on the scheduling of the appointment.

Contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following requirements:

(A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;

(B) Non-urgent appointments shall be offered within 36 business days of the request for appointment, except as provided in (C) below; and

(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.

Telephone triage or screening services are provided in a timely manner appropriate for the insured's condition. During normal business hours, the waiting time for a Covered Person to speak by telephone with a customer service representative knowledgeable and competent regarding the Covered Person's questions and concerns will not exceed ten minutes.

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

Dental Benefit Providers of California, Inc.

William J Golden, President

Virtual Visits Dental Amendment

Dental Benefit Providers of California, Inc.

As described in this Amendment, the Contract is modified to provide Virtual Visits for teledentistry.

Virtual visits for some Covered Dental Services through store and forward technologies, live consultation, and mobile health. This includes, but is not limited to, real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient dental information, including diagnostic-quality digital images and laboratory results for dental interpretation and diagnosis, for the purpose of delivering dental services and information.

Coverage for Dental Services provided through Virtual Visits shall be equivalent to the Coverage for the same Services provided via face-to-face contact between a Dentist and a Covered Person. Nothing in this section shall require a Dentist to be physically present with the Covered Person.

We will not exclude a Dental Service for Coverage solely because such Dental Service is provided only through Virtual Visits and not through in-person consultation between the Covered Person and a Dentist, provided Virtual Visits are appropriate for the provision of such Dental Services.

Benefits are available only when services are delivered through a Participating Dentist. You can find a Participating Dentist by contacting us at www.myuhc.com or by calling us at 1-800-445-9090.

Please Note: Not all dental conditions can be treated through virtual visits. The Dentist will identify any condition for which treatment by in-person contact is needed.

Benefits do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical and/or dental facilities.

All terms and conditions of the Contract remain in full force and effect except to the extent modified by this Amendment.

Dental Benefit Providers of California, Inc.

William J Golden, President

LANGUAGE ASSISTANCE SERVICES

English
IMPORTANT LANGUAGE INFORMATION:
You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. If you need more help, call HMO Help Line at 1-888-466-2219.

Spanish
INFORMACIÓN IMPORTANTE SOBRE IDIOMAS:
Es probable que usted disponga de los derechos y servicios a continuación. Puede pedir un intérprete o servicios de traducción sin cargo. Es posible que tenga disponible documentación impresa en algunos idiomas sin cargo. Para recibir ayuda en su idioma, llame a su plan de salud de UnitedHealthcare of California al 1-800-624-8822 / TTY: 711. Si necesita más ayuda, llame a la línea de ayuda de la HMO al 1-888-466-2219.

Chinese
重要語言資訊：
您可能有資格享有下列權利並取得下列服務。您可以免費獲取口譯員或翻譯服務。部分語言亦備有免費書面資訊。如需取得您語言的協助，請撥打下列電話與您的健保計畫聯絡：UnitedHealthcare of California 1-800-624-8822 / 聽力語言殘障服務專線 (TTY)：711。若您需要更多協助，請撥打 HMO 協助專線 1-888-466-2219。

Arabic
معلومات مهمة عن اللغة:
ربما تكون مؤهلاً للحصول على الحقوق والخدمات أدناه. فيمكنك الحصول على مترجم فوري أو خدمات الترجمة بدون رسوم. وربما تتوفر أيضًا المعلومات المكتوبة بعدة لغات بدون رسوم. وللحصول على مساعدة بلغتك، يُرجى الاتصال بخطتك الصحية على: UnitedHealthcare of California على الرقم 1-800-624-8822 / TTY: 711. وإذا احتجت لمزيدٍ من المساعدة، يمكنك الاتصال بخط المساعدة التابع لـ HMO على الرقم 1-888-466-2219.

Armenian
ԿԱՐԵՎՈՐ ԼԵԶՎԱԿԱՆ ՏԵՂԵԿՈՒԹՅՈՒՆ՝
Հավանական է, որ Ձեզ հասանելի լինեն հետևյալ իրավունքներն ու ծառայությունները: Կարող եք ստանալ բանավոր թարգմանչի կամ թարգմանության անվճար ծառայություններ: Հնարավոր է, որ մի շարք լեզուներով նաև առկա լինի անվճար գրավոր տեղեկություն: Ձեր լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել Ձեր առողջապահական ծրագիր՝ UnitedHealthcare of California 1-800-624-8822 / TTY՝ 711 համարով: Հավելյալ օգնության կարիքի դեպքում, զանգահարեք HMO-ի Օգնության հեռախոսազիծ 1-888-466-2219 համարով:

Cambodian
ព័ត៌មានសំខាន់អំពីភាសា៖
អ្នកអាចនឹងមានសិទ្ធិ ចំពោះសិទ្ធិ និងសេវានៅខាងក្រោម។ អ្នកអាចទទួលអ្នកបកប្រែ ឬសេវាការបកប្រែ ដោយឥតគិតថ្លៃ។ ព័ត៌មានដែលបានសរសេរ ក៏អាចនឹងមានជាភាសាមួយចំនួន ដោយឥតគិតថ្លៃដែរ។ ដើម្បីទទួលជំនួយជាភាសារបស់អ្នក សូមទូរស័ព្ទទៅគម្រោងសុខភាពរបស់អ្នក តាមលេខ៖ UnitedHealthcare of California 1-800-624-8822 / TTY: 711។ ប្រសិនអ្នកត្រូវការជំនួយថែមទៀត ហៅខ្សែទូរស័ព្ទជំនួយ HMO តាមលេខ 1-888-466-2219។

Farsi

اطلاعات مهم در مورد زبان:

شما ممکن است برای حقوق و خدمات زیر واجد شرایط باشید. می توانید خدمات مترجم شفاهی یا ترجمه را بدون پرداخت هزینه‌دریافت کنید. اطلاعات کتبی ممکن است بدون پرداخت هزینه به برخی زبان ها موجود باشد. برای دریافت کمک و راهنمایی به زبان خودتان، لطفاً با برنامه درمانی: UnitedHealthcare of California به شماره 1-800-624-8822/TTY: 711. تماس بگیرید. اگر به کمک و راهنمایی بیشتری نیاز دارید، با خط دریافت کمک و راهنمایی HMO به شماره 1-888-466-2219 تماس بگیرید.

Hindi

भाषा-संबंधी महत्वपूर्ण जानकारी:

आप निम्नलिखित अधिकारों और सेवाओं के हकदार हो सकते हैं। आपको मुफ़्त में दुभाषिया या अनुवाद सेवाएँ उपलब्ध कराई जा सकती हैं। कुछ भाषाओं में लिखित जानकारी भी आपको मुफ़्त में उपलब्ध कराई जा सकती हैं। अपनी भाषा में सहायता प्राप्त करने के लिए, कृपया अपने स्वास्थ्य प्लान को यहाँ कॉल करें: UnitedHealthcare of California 1-800-624-8822 / TTY: 711। पर। अतिरिक्त सहायता की आवश्यकता पड़ने पर, HMO Help Line को 1-888-466-2219 पर कॉल करें।

Hmong

COV NTAUB NTAWV LUS TSEEM CEEB:

Tej zaum koj yuav muaj cai rau cov cai pab cuam hauv qab no. Koj tuaj yeem tau txais ib tug kws txhais lus los sis txhais ntawv pub dawb. Cov ntaub ntawv sau no muaj sau ua qee yam ntaub ntawv pub dawb rau sawd daws. Yuav tau txais kev cov ntaub ntawv sau ua koj lus, thov hu rau qhov chaw npaj kho mob rau ntawm: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Yog koj xav tau kev pab ntxiv, hu rau HMO Help Line ntawm tus xov tooj 1-888-466-2219.

Japanese

言語支援サービスについての重要なお知らせ：

お客様には、以下権利があり、必要なサービスをご利用いただける可能性があります。お客様は、通訳または翻訳のサービスを無料でご利用いただけます。言語によっては、文書化された情報を無料でご利用できる場合もあります。ご希望の言語による援助をご希望の方は、お客様の医療保険プランにご連絡ください。UnitedHealthcare of California 1-800-624-8822 / TTY: 711。この他のサポートが必要な場合には、HMO Help Line に 1-888-466-2219 にてお問い合わせください。

Korean

중요 언어 정보:

귀하는 아래와 같은 권리 및 서비스를 누리실 수 있습니다. 귀하는 통역 혹은 번역 서비스를 비용 부담없이 이용하실 수 있습니다. 일부 언어의 경우 서면 번역 서비스 또한 비용 부담없이 제공될 수도 있습니다. 귀하의 언어 지원 서비스가 필요하시면 귀하의 건강보험에 다음 전화번호로 문의하십시오. UnitedHealthcare of California 1-800-624-8822 / TTY: 711. 더 많은 도움이 필요하신 분은 HMO 헬프 라인(안내번호: 1-888-466-2219)으로 문의하십시오.

Punjabi
ਮਹੱਤਵਪੂਰਨ ਭਾਸ਼ਾ ਦੀ ਜਾਣਕਾਰੀ:

ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾ ਕਿਸੇ ਲਾਗਤ 'ਤੇ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਬਿਨਾ ਕਿਸੇ ਖਰਚੇ ਦੇ ਮਿਲ ਸਕਦੀ ਹੈ। ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ: UnitedHealthcare of California 1-800-624-8822 / TTY: 711। ਜੇ ਤੁਹਾਨੂੰ ਹੋਰ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ HMO ਹੈਲਪ ਲਾਈਨ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-466-2219।

Russian
ВАЖНАЯ ЯЗЫКОВАЯ ИНФОРМАЦИЯ:
Вам могут полагаться следующие права и услуги. Вы можете получить бесплатную помощь устного переводчика или письменный перевод. Письменная информация может быть также доступна на ряде языков бесплатно. Чтобы получить помощь на вашем языке, пожалуйста, позвоните по номеру вашего плана: UnitedHealthcare of California 1-800-624-8822 / линия TTY: 711. Если вам все еще требуется помощь, позвоните в службу поддержки HMO по телефону 1-888-466-2219.

Tagalog
MAHALAGANG IMPORMASYON SA WIKA:
Maaaring kwalipikado ka sa mga karapatan at serbisyo sa ibaba. Maaari kang kumuha ng interpreter o mga serbisyo sa pagsasalin nang walang bayad. Maaaring may available ding libreng nakasulat na impormasyon sa ilang wika. Upang makatanggap ng tulong sa iyong wika, mangyaring tumawag sa iyong planong pangkalusugan sa: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Kung kailangan mo ng higit pang tulong, tumawag sa HMO Help Line sa 1-888-466-2219.

Thai
ข้อมูลสำคัญเกี่ยวกับภาษา :
คุณอาจมีสิทธิ์ได้รับสิทธิและบริการต่าง ๆ ด้านล่างนี้ คุณสามารถขอล่ามแปลภาษาหรือบริการแปลภาษาได้ โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด นอกจากนี้ ยังอาจมีข้อมูลเป็นลายลักษณ์อักษรบางภาษาให้ด้วย โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด หากต้องการขอความช่วยเหลือเป็นภาษาของคุณ โปรดโทรศัพท์ถึงแผนสุขภาพของคุณที่ : UnitedHealthcare of California 1-800-624-8822 / สำหรับผู้มีความบกพร่องทางการฟัง : 711 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ให้ความช่วยเหลือเกี่ยวกับ HMO ที่หมายเลขโทรศัพท์ 1-888-466-2219

Vietnamese
THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:
Quý vị có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể yêu cầu được cung cấp một thông dịch viên hoặc các dịch vụ dịch thuật miễn phí. Thông tin bằng văn bản cũng có thể sẵn có ở một số ngôn ngữ miễn phí. Để nhận trợ giúp bằng ngôn ngữ của quý vị, vui lòng gọi cho chương trình bảo hiểm y tế của quý vị tại: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Nếu quý vị cần trợ giúp thêm, xin gọi Đường dây hỗ trợ HMO theo số 1-888-466-2219.

NOTICE OF NON-DISCRIMINATION

We do not treat members differently because of sex, age, race, color, disability, national origin, ancestry, religion, marital status, gender, gender identity, or sexual orientation.

If you think you were treated unfairly because of your sex, age, race, color, disability, national origin ancestry, religion, marital status, gender, gender identity, or sexual orientation, you can send a complaint to:

Civil Rights Coordinator

United HealthCare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-800-445-9090 TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m.

In cases of discrimination based on race, color, national origin, age, disability or sex, you can also file a complaint with the U.S. Dept. of Health and Human services.

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

Grievance Procedures

If you or one of your eligible dependents has a grievance with us or your dentist, you may orally submit such grievance by calling our Customer Service Department at (877) 813-4259 or 1-877-735-2929 (TDHI) or 711 (TTY/TDD). We will permit grievances which are filed within 180 days of the occurrence or incident that is the subject of the grievance.

You may also submit a completed written grievance form (available by calling the Customer Service number), and it will be promptly provided. If you prefer, you may also submit a detailed summary of your grievance to:

Dental Benefit Providers of California, Inc.

Dental Appeals

P.O. Box 30569

Salt Lake City, UT 84130-0569

Fax: 714-364-6266

Please be sure to include your name (patient's name, if different), Member Identification Number, facility (or Selected General Dentist) name and number on all written correspondence.

We agree, subject to our Complaint Procedure, to duly investigate and endeavor to resolve any and all complaints received from Members regarding the plan. We will confirm receipt of your complaint in writing within five (5) calendar days of receipt. We will resolve the complaint and communicate the resolution in writing within thirty (30) calendar days.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-877-813-4259 and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30

days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Website http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

In the event of an urgent grievance, which involves an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life, limb or major bodily function, you are not required to participate in our grievance process and may directly contact the California Department of Managed Health Care, as referenced above, for review of the urgent grievance.

A guardian may file a grievance on behalf of a minor or someone who is incompetent or incapacitated.

There will be no discrimination against you, including cancellation of your insurance, on the grounds that you filed a grievance.

Grievances Involving the Cancellation, Rescission or Non-Renewal of Health Plan

If you believe that your dental plan enrollment or subscription has been, or will be improperly rescinded, canceled, or not renewed, you have the right to file a complaint. A complaint is also called a grievance or an appeal.

First, file your complaint with Dental Benefit Providers of California, Inc

You can file a complaint by calling our Customer Service department at Customer Service Department at (877) 813-4259 or 1-877-735-2929 (TDHI) or 711 (TTY/TDD) or you may also submit a detailed summary of your grievance to:

Dental Benefit Providers of California, Inc.

Dental Appeals

P.O. Box 30569

Salt Lake City, UT 84130-0569

Fax: 714-364-6266

- You should file your complaint as soon as possible after you receive notice that your dental plan enrollment or subscription will be rescinded, canceled or not renewed.
- If your problem is urgent, Dental Benefit Providers of California, Inc, must give you a decision within 3 days. Your problem is urgent if there is a serious threat to your health that must be resolved quickly.
- If your problem is not urgent, Dental Benefit Providers of California, Inc, must give you a decision within 30 days.

Take your complaint to the California Department of Managed Health Care (DMHC)

The DMHC oversees HMOs and other health plans in California and protects the rights of HMO members. You can file a complaint with the DMHC if:

- You are not satisfied with Dental Benefit Providers of California, Inc,'s decision about your complaint, or;
- You have not received the decision within 30 days, or within 3 days if the problem is urgent.

- The DMHC may allow you to submit a complaint directly to the DMHC, even if you have not filed a complaint with Dental Benefit Providers of California, Inc., if the DMHC determines that your problem requires immediate review.

If you need help with this process, contact the DMHC Help Center at the toll-free telephone number (1-888-HMO-2219), or submit an inquiry in writing to the DMHC, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725 or through the website: http://www.hmohelp.ca.gov.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after dental care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require prior authorization or benefit confirmation prior to receiving dental care.

How to Request an Appeal

If you disagree with a pre-service request for benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and Policy number.
- The date(s) of Dental Service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a Dental care professional with experience in the field, who was not involved in the prior determination. We may consult with, or ask dental experts to take part in the appeal process. You consent to this referral and the sharing of needed dental claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for benefits.
- For appeals of post-service claims as identified above, the appeal will take place and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization* (*IRO*) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Dental Provider should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Dental Provider 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 appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

DENTAL PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

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 January 1, 2019

We[2] 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. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health care condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular dental plan, we will post the revised notice on your dental plan website, such as www.myuhc.com. We have the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollee information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

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

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice.
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

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

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may use or disclose health information as needed to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.

- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.

- **For Plan Sponsors.** If your coverage is through an employer sponsored 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 restrictions on its use and disclosure of the information in accordance with federal law.

- **For Underwriting Purposes**. We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.

- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as 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:

- **As Required by Law.** We may disclose information when required to do so by law.

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.

- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.

- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.

- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, 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.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

- **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** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the review of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To 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 needed to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is needed for such functions or services. Our business associates are required, under contract with us and according to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as shown in our contract as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

    1. Alcohol and Substance Abuse
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic Information
    6. HIV/AIDS
    7. Mental Health
    8. Minors' Information
    9. Prescriptions
    10. Reproductive Health
    11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as stated in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you,

selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number listed on your dental plan ID card.

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 authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our 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). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

- **You have the right to see and get a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.

- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. 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 certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which 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 also may get a copy of this notice on your dental plan website, such as www.myuhc.com.

Exercising Your Rights

- **Contacting your Dental Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your dental ID card or you may call us at 1-800-445-9090, or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

  UnitedHealthcare

  Dental HIPAA - Privacy Unit

  PO Box 30978

  Salt Lake City, UT 84130

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

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.

[2]*This Dental Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; National Pacific Dental, Inc.; Unimerica Insurance Company; UnitedHealthcare Insurance Company and UnitedHealthcare Insurance Company of New York. This list of dental plans is complete as of the effective date of this notice. For a current list of dental plans subject to this notice go to www.uhc.com/privacy/entities-fn-v5.*

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2019

We[3] 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.

Information We Collect

Depending upon the product or service you have with us, we may 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, medical information and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your dental plan ID card or call us at 1-800-445-9090, or TTY 711.

[3]*For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Dental Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliate: Dental Benefit Providers, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to any other UnitedHealth Group health*

plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of dental plans is complete as of the effective date of this notice. For a current list of dental plans subject to this notice go to www.uhc.com/privacy/entities-fn-v5.