UnitedHealthcare PPO Dental

UnitedHealthcare Insurance Company

Certificate of Coverage

For

AIMS Benefit Trust

Dental Plan Number: 04H95

Enrolling Group Number: 717578

Effective Date: January 1, 2023

Certificate of Coverage

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

877-294-1429

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Group. The *Certificate* describes Covered Dental Care Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Group's *Application* and payment of the required Policy Charges.

In addition to this *Certificate*, the Policy includes:

- The *Schedule of Covered Dental Care Services*.
- The Group's *Application*.
- Riders.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

Can This Certificate Change?

We may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When this happens we will send you a new *Certificate*, Rider or Amendment.

A change in the Policy is not valid:

- Until approved by an executive officer of the company; and
- Unless the approval is endorsed on the Policy or attached to the Policy.

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends*.

We are delivering the Policy in Maryland. The Policy is governed by ERISA unless the Group is not an employee health and welfare plan as defined by ERISA. To the extent that state law applies, Maryland law governs the Policy.

Introduction to Your Certificate

This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

How Do You Use This Document?

Read your entire *Certificate* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Certificate* and *Schedule of Covered Dental Care Services* and any attachments in a safe place for your future reference.

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Covered Dental Care Services* along with *Section 1: Covered Dental Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *Certificate* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

If there is a conflict between this *Certificate* and any summaries provided to you by the Group, this *Certificate* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact Us?

Call us at 1-800-445-9090. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Policy issued to your Group, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy. If you have questions about this, contact your Group.

Be Aware the Policy Does Not Pay for All Dental Care Services

The Policy does not pay for all dental care services. Benefits are limited to Covered Dental Care Services. The *Schedule of Covered Dental Care Services* will tell you the portion you must pay for Covered Dental Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Dental Provider. We do not make decisions about the kind of care you should or should not receive.

Choose Your Dental Provider

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

Pay Your Share

You must meet any applicable deductible and pay a Co-payment and/or Co-insurance for most Covered Dental Care Services. These payments are due at the time of service or when billed by the Dental Provider or facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Covered Dental Care Services*. You must also pay any amount that exceeds the Allowed Amount.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions.

File Claims with Complete and Accurate Information

When you receive Covered Dental Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether the Policy will pay for any portion of the cost of a dental care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the final authority to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Covered Dental Care Services* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may assign this authority to other persons or entities that may provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Dental Care Services

We pay Benefits for Covered Dental Care Services as described in *Section 1: Covered Dental Care Services* and in the *Schedule of Covered Dental Care Services*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Dental Care Services. It also means that not all of the dental care services you receive may be paid for (in full or in part) by the Policy.

Pay Network Providers

It is the responsibility of Network Dental Providers and facilities to file for payment from us. When you receive Covered Dental Care Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Dental Care Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, we pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*. Your cost sharing may be more when you see an out-of-Network Dental Provider.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, as we determine, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Dental Terminology* (publication of the *American Dental Association*).
- As reported by generally recognized professionals or publications.
- As used for Medicare.

- As determined by medical or dental staff and outside medical or dental consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Dental Providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network Dental Providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Dental Provider or provider by contacting us at www.myuhc.com or by calling us at 1-800-445-9090.

Certificate of Coverage Table of Contents

Section 1: Covered Dental Care Services

When Are Benefits Available for Covered Dental Care Services?

Benefits are available only when all of the following are true:

- The dental care service, including supplies or Pharmaceutical Products, is only a Covered Dental Care Service if it is Necessary. (See definitions of Necessary and Covered Dental Care Service in *Section 9: Defined Terms*.)
- You receive Covered Dental Care Services while the Policy is in effect.
- You receive Covered Dental Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Dental Care Services is a Covered Person and meets all eligibility requirements specified in the Policy.

The fact that a Physician or other Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease or its symptoms does not mean that the procedure or treatment is a Covered Dental Care Service under the Policy.

If we determine that a service, less costly than the Covered Dental Care Service the Dental Provider performed, could have been performed to treat a dental condition, we will pay Benefits based on the less costly service if such service:

- Would produce a professionally acceptable result under generally accepted dental standards and
- Would qualify as a Covered Dental Care Service

One example is:

- When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar. We may base our benefit determination on the amalgam filling which is the less costly service.

If we pay Benefits based on the less costly service, the Dental Provider may charge you or your dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dental Provider.

This section describes Covered Dental Care Services for which Benefits are available. Please refer to the attached *Schedule of Covered Dental Care Services* for details about:

- The amount you must occur for these Covered Dental Care Services (including any Deductibles, Co-payment and/or Co-insurance).
- Any limit that applies to these Covered Dental Care Services (frequency and dollar limits on services and/or materials and waiting periods).

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Classes of Dental Benefits

Below are descriptions of various dental care services. **Please check your *Schedule of Covered Dental Care Services* to verify what dental Benefits are available to you**. Any Covered Dental Care Service in one Class can be shifted to another Class.

Class I - Dental Benefits

Diagnostic and Preventive Services - routine or basic dental services and procedures to evaluate existing oral health status and conditions and the procedure to prevent oral disease. These dental care services include exams and evaluations, prophylaxis, space maintainers, and preventive fluoride treatments.

Emergency Palliative Treatment - dental emergency treatment to temporarily relieve pain, swelling or bleeding.

Radiographs - x-rays required for routine exams to assist in diagnosing treatment and/or as necessary for the diagnosis of a specific condition.

Class II - Dental Benefits

Adjunctive Services - dental care which is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition and is essential to the control of the primary medical condition; or, is required in preparation for, or as the result of, dental trauma which may be or is caused by medically necessary treatment of an injury or disease.

Endodontic Services - the treatment of nerve and blood vessels inside the teeth, within the tooth's root canals.

Oral Surgery Services - extractions and other dental surgery of the mouth and jaw, including pre-operative and post-operative care.

Periodontic Services - the treatment of diseases of the gums and supporting bone structures of the teeth. This includes periodontal recall and maintenance (periodontal prophylaxes) following active periodontal therapy.

Relines and Repairs - relines and repairs to bridges, partial dentures and complete dentures.

Restorative Services - services to repair and/or replace natural tooth structure damaged or loss by disease or injury. Restorative services include:

- Minor restorative services, such as amalgam (silver) fillings and composite resin (tooth colored) fillings.
- Major restorative services such as crowns and onlays, used when teeth cannot be restored with amalgam or resin fillings.

Sealants - mechanically and/or chemically prepared enamel surface sealed to prevent decay.

Space Maintainers - passive appliances are designed to prevent tooth movement.

Class III - Dental Benefits

Brush Biopsy - diagnostic test to take a small sample from the mouth for a lab to complete an analysis to detect early oral cancer.

Implants - services for replacement of implants, implant crowns, implant prostheses, and implant supporting structures (such as connectors).

Prosthodontic Services - services and appliance that replace missing natural teeth (such as bridges, dental implants, partial dentures, and complete dentures).

Removable Dentures - replacement of complete dentures, fixed and removable partial dentures, crowns, inlays or onlays.

Class IV - Dental Benefits

Orthodontic Services - services, treatments, and procedures to correct malposed teeth (braces). Orthodontic Services can be for children or adults.

2. Virtual Visits

Virtual visits for some Covered Dental Care 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 care services and information.

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

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

Network Benefits are available only when services are delivered through a Network Dental Provider. You can find a Network Dental Provider 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 Dental Provider 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.

3. Prenatal Dental Care

Any required Co-payment, Deductible, Waiting Period or Maximum Benefit is waived for a Covered Person through all trimesters of their pregnancy as well as three months post-delivery for the following Covered Dental Care Services: prophylaxis - adult, periodontal scaling and root planing - four or more teeth per quadrant, periodontal scaling and root planing - one - three teeth per quadrant, periodontal maintenance, periodic oral evaluation, radiographs, lab and other diagnostic tests, full mouth debridement to enable comprehensive evaluation and diagnosis.

Credit for Prior Coverage

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

Pre-Treatment Estimate

If the charge for a Dental Care Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a Pre-Treatment Estimate. If you desire a Pre-Treatment Estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must

provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

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

Pre-Treatment Estimate of benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment. The pre-treatment estimate is valid for 90 calendar days from the date we provide it to the Dental Provider. If you will not receive the services within the 90 calendar days, you or the Dental Provider must request another pre-treatment estimate from us.

Section 2: Exclusions and Limitations

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, and materials described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician or Dental Provider.
- It is the only available treatment for your condition.

The services, treatments, and materials listed in this section are not Covered Dental Care Services, except as may be specifically provided for in *Section 1: Covered Dental Care Services* or through a Rider to the Policy.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Dental Care Service categories described in *Section 1: Covered Dental Care Services*, those limits are stated in the corresponding Covered Dental Care Service category in the *Schedule of Covered Dental Care Services*. Limits may also apply to some Covered Dental Care Services that fall under more than one Covered Dental Care Service category. When this occurs, those limits are also stated in the *Schedule of Covered Dental Care Services* table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

Exclusions

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

1. Dental Care Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. Any treatment, device or pharmacological regimen that is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be an Experimental, Investigational or Unproven Service.
8. Any implant procedures performed which are not listed as covered implant procedures in the *Schedule of Covered Dental Care Services*.

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

10. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to you by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

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

12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms of hard or soft tissue including excision.

13. 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 Dental Provider. If replacement is due to patient non-compliance, the patient is liable for the cost of replacement.

14. 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.

15. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice, or the notice period as required by the Dental Provider in question.

16. Expenses for Dental Procedures begun prior to you becoming enrolled under the Policy.

17. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

18. 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.

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

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

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

22. Services rendered by a provider with the same legal residence as you or who is a member of your family, including but not limited to: spouse, brother, sister, parent or child.

23. Dental Care Services otherwise covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Care Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.

24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

25. Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, surgical procedure to correct a malocclusion, replacement of lost or broken retainers, and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan within 120 months of initial or supplemental placement.

26. In the event that an out-of-Network Dental Provider waives, does not pursue, or fails to collect, Co-payments, Co-insurance and/or any deductible or other amount owed for a particular dental care service, no Benefits are provided for the dental care service when the Co-payments, Co-insurance and/or deductible are waived.

27. Foreign Services are not covered unless required as an Emergency.

28. Dental Care 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.

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

30. Services rendered while covered under this Policy which were also covered by a prior carrier will be reviewed based on current Policy Coverage. Any Policy Exclusions and/or limitations will apply based on when the Covered Dental Care Service was originally rendered, even when rendered while covered under a prior carrier.

31. Any Dental Care Service Covered under an essential health benefit plan is not covered under this Policy except for Orthodontic Dental Care Services.

32. Major restorative services relating to teeth that are not periodontally sound or that have a questionable prognosis of less than five years.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Group. The Group will submit the completed forms to us, along with any required Premium. We will not provide Benefits for dental care services that you receive before your effective date of coverage, except for the following instances:

- Enrollees who:
  - Are transitioning from the Maryland Medical Assistance Program and who are receiving dental benefits that were previously authorized by a third-party administrator.
  - Had Covered Health Care Services authorized by the previous carrier for:
    - the procedures, treatments, medications or services covered by the benefits offered by Us under your plan; and the following time periods:
      - the lesser of the course of treatment or 90 days.

  We may request a copy of the prior authorization from the previous carrier, with the consent of an enrollee or an enrollee's parent, guardian, or designee, which must be submitted to Us within 10 days after receipt of the request. After the above noted timeframes have lapsed, We may elect to perform our own utilization review in order to reassess and make Our own determination regarding the need for continued treatment and to authorize any continued procedure, treatment, medication or service determined to be medically necessary.
- Enrollees who have been receiving covered dental care services from an Out-of-Network provider may continue to receive services for the following time period of the lesser of the course of treatment or 90 days from that provider when the services are for the following:
  - Acute conditions.
  - Serious chronic conditions, and
  - Any other condition on which we and the Out-of-Network provider reach agreement.

  The copayments, deductibles, and any coinsurance required of an enrollee for the services rendered in accordance with the above noted conditions are the same as those that would be required if the enrollee were receiving the services from a participating provider.

Who Is Eligible for Coverage?

The Group determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 9: Defined Terms*.

Eligible Persons must live within the United States.

If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event.

In addition, the following rules apply in accordance with state law:

- The newborn child of the Subscriber or the Subscriber's spouse is covered automatically from the moment of birth for at least 31 days.
- The newborn grandchild of the Subscriber or the Subscriber's spouse is covered automatically from the moment of birth for at least 31 days, if the newborn grandchild is a dependent of the Subscriber/Subscriber's spouse and is in the court-ordered custody of the Subscriber/Subscriber's spouse.
- The newly adopted child or grandchild of the Subscriber or the Subscriber's spouse is covered automatically from the date of adoption for at least 31 days. "Date of adoption" means the earlier of a judicial decree of adoption, or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.
- A newly eligible grandchild is covered automatically from the date the grandchild is placed in the court ordered custody of the Subscriber or the Subscriber's spouse.
- The child in the custody of the Subscriber or the Subscriber's spouse as a result of a guardianship of more than 12 months duration granted by a court or testamentary appointment is covered automatically from the date of such appointment for at least 31 days.

If payment of a specific Premium is required to provide coverage for any of the above, we will require notification and payment of the required Premium be furnished to us within 31 days after the birth, adoption, or date of court or testamentary appointment in order to have coverage continued beyond the 31 day period.

In addition, the following rules apply in accordance with state law for a court or an administrative order:

The child of a Subscriber for whom the court or the support enforcement agency has ordered the Subscriber to provide health care coverage is covered automatically from the date of the order.

The Subscriber must pay any applicable Premium necessary to provide coverage for such child. When the Subscriber does not include the child in the enrollment, we will allow the non-insuring parent, the support enforcement agency, or the *Department of Health and Mental Hygiene* to apply for the enrollment on behalf of the child and include the child in the coverage under the Policy.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Registering a Domestic Partner.

- Death of a spouse.
- Involuntary termination of a spouse's coverage under another plan.

With regard to the last two bullet points above, if the special enrollment period applies because prior coverage under another plan that ended due to the death or involuntary termination of a spouse, enrollment and payment of Premium for coverage under this plan must occur within six months of the date the prior coverage ended. Evidence of insurability is not required.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing dental coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including legal separation, divorce or death).
    - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
    - In the case of COBRA continuation coverage, the coverage ended.
    - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
    - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
    - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing dental coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Coverage of Children

A Dependent child of the Subscriber may enroll at any time and without evidence of insurability if:

A. The Dependent child was previously covered under the policy or contract of the Subscriber's spouse; and

B. The Subscriber's spouse has died.

This applies regardless of whether a Subscriber's dependent children are eligible for any continuation or conversion privileges under the policy or contract of the Subscriber's spouse.

The Subscriber must exercise the benefit within 6 months after the death of the spouse.

Coverage for Children Under a Medical Child Support Order

When you are required by a medical child support order to provide dental insurance for a child, the Company will permit you to enroll the child without regard to any enrollment period restrictions and add the child for dental insurance upon enrollment made by the child's non-insuring parent, by the Department of Health and Mental Hygiene, or by the state agency administering a child support enforcement program if you fail to enroll the child.

The Company will not add a child for dental insurance unless you are also insured. If you are not insured, the Company will permit you to enroll for dental insurance without regard to any enrollment period restrictions. The Company will notify you within 20 business days of receipt of medical support notice from the employer. We will determine if the notice contains the employee's name and mailing address and the child's name and the child's mailing address or the address of a substituted official.

The Company will not terminate the child's dental insurance unless satisfactory written evidence is provided that the court order is no longer in effect; the child is or will be enrolled in a comparable dental plan with another insurer that will take effect not later than the termination date of this insurance; or Dependent insurance is no longer available or the employer no longer employs the insuring parent, except that if the parent elects to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage shall be provided for the child consistent with the employer's plan for postemployment dental insurance coverage for dependents.

The Company will provide to the non-insuring parent ID cards, claims forms, and any other information necessary for the child to obtain benefits through the health insurance coverage; and process the claims forms and make appropriate payment to the non-insuring parent, health care provider, or Department of Health and Mental Hygiene if the non-insuring parent incurs expenses for health care provided to the child.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

Your right to Benefits automatically ends on the date that coverage ends, except as noted below under *Extension of Coverage*. When your coverage ends, we will still pay claims for Covered Dental Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any dental care services received after that date.

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In this event, the Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends on the date we receive the required notice from the Group to end your coverage, or on the date requested in the notice, if later.

- **Subscriber Retires or Is Pensioned**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends the date the Subscriber is retired or receiving benefits under the Group's pension or retirement plan.

  This provision applies unless there is specific coverage classification for retired or pensioned persons in the Group's *Application*, and only if the Subscriber continues to meet any applicable eligibility requirements. The Group can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 30 days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is incapacitated will not end just because the child has reached a certain age. We will extend the coverage for that child beyond this age if both of the following are true:

The Enrolled Dependent child is not able to support him/herself because of mental or physical incapacity that originated before the Enrolled Dependent child attained the limiting age.

The Enrolled Dependent child depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as incapacitated and dependent unless coverage otherwise ends in accordance with the terms of the Policy.

You must furnish us with proof of the medical certification of incapacitated within 31 days after the date coverage would have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at our expense. We will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Extended Coverage

We only pay Benefits for Covered Dental Care Services incurred by a Covered Person while you are insured by this plan for the following:

- Benefits for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared.
- Benefits for any other dental prosthesis is incurred on the date the first master impression is made.
- Benefits for root canal treatment is incurred on the date the pulp chamber is opened.
- Benefits for orthodontic treatment is incurred on the date the active orthodontic appliance is first placed.

All other Benefits for Covered Dental Care Services are incurred on the date the services are furnished. If a specific treatment is started while a Covered Person is insured, we will only pay Benefits for Covered Dental Care Services which are completed within 31 days of the date your coverage under this plan ends.

A temporary extension of coverage will be given to a Covered Person who meets one or more of the following conditions on the date the Covered Person's coverage ends:

- The Covered Person is Totally Disabled.
- The Covered Person is undergoing treatment other than treatment for an accidental dental injury.
- The Covered Person is in a Hospital.

The temporary extension will continue until (a) the day the Total Disability or treatment ends; or (b) 12 months from the date coverage under the Policy would otherwise have ended whichever occurs first. No Premium will be charged for this coverage extension.

With regard to an extension of coverage due to Total Disability, we may request proof of disability at any time.

With regard to the Covered Person undergoing dental treatment as part of an accidental injury the temporary extension will continue for a period of 90 days from the date coverage under the Policy would otherwise have ended if the dental treatment:(1) begins before the date coverage ends; and (2) requires two or more visits on separate days to the dentist's office.

With regard to Orthodontics, if coverage is provided, shall provide covered benefits, in accordance with the policy in effect at the time the coverage terminated, for orthodontics:

- For 60 days after the date coverage terminates if the orthodontist has agreed to or is receiving monthly payments; or
- Until the later of 60 days after the coverage terminates or the end of the quarter in progress; if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

Note: If the Covered Person becomes covered under another health plan on the date following the date coverage ends under this Policy and (1) the coverage provided by the new health benefit plan is provided at a cost to the individual that is less than or equal to the cost to the individual as the extended Benefit provided under this Policy and (2) the new coverage does not result in an interruption of benefits, this temporary extension of coverage does not apply.

Continuation of Coverage

If your coverage ends under the Policy, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Group is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Continuation of Coverage under State Law for Surviving Spouses and Children

An Enrolled Dependent whose coverage under the Policy would otherwise end due to the death of the Subscriber is entitled to continue coverage as described in this section. This right to continue coverage also applies to a newborn child who is born to the Enrolled Dependent spouse after the date of the Subscriber's death. In order for an Enrolled Dependent to continue coverage, the Subscriber must have been continuously covered under the Policy (or a predecessor group policy with the same Group) for a period of at least 3 months prior to his or her death and the Enrolled Dependent spouse must have been continuously covered under the Policy (or a predecessor group policy with the same Group) for a period of at least 30 days prior to his or her death.

If the Enrolled Dependent spouse or child wishes to continue coverage, he or she must request that the Group provide an election notification form. Within 14 days of the receipt of the request, the Group will deliver or send by first-class mail an election notification form. Continuation coverage must be elected within 45 days of the date of the Subscriber's death and the Enrolled Dependent must make any required payment for coverage to the Group.

Continued coverage shall end on the earlier of the following dates:

- Eighteen (18) months after the date continuation coverage began;
- For a Dependent child, the date coverage would otherwise end as described in Section 4: When Coverage Ends;
- The date coverage ends for failure to make timely payment of the Premium;
- The date on which the Covered Person becomes eligible for hospital, medical, or surgical benefits under an insured or self-insured group health benefit program or plan, other than the group contract, that is written on an expense-incurred basis or is with a health maintenance organization;
- The date the Covered Person accepts hospital, medical, or surgical coverage under a non-group contract of policy that is written on an expense-incurred basis or is with a health maintenance organization;
- The date the Covered Person becomes entitled to benefits under *Title XVIII of the Social Security Act*; or
- The date the Covered Person elects to end coverage.

Continuation of Coverage under State Law for Divorced Spouses and Children

An Enrolled Dependent whose coverage under the Policy would otherwise end due to divorce from the Subscriber is entitled to continue coverage as described in this section. This right to continue coverage also applies to a newborn child who is born to the Enrolled Dependent spouse after the date that coverage would have otherwise end due to divorce.

If the Enrolled Dependent spouse or child wishes to continue coverage, he or she or the Subscriber must notify the Group of the divorce. This notification must be provided not later than described in (1) or (2) below.

(1) 60 days after the applicable change in status if on the date of the change the Subscriber is covered under the Policy or under another group contract issued to the same Group. In this case coverage will be effective retroactive to the date of the applicable change in status.

(2) 30 days after the date the insured employee becomes eligible for coverage under a group contract issued to another employer, if the insured employee becomes covered under the new employer's group contract after the applicable change in status. In this case, coverage shall be retroactive to the date of eligibility.

The Subscriber or the divorced spouse must make any required payment for coverage to the Group, either through payroll deduction or other mutually agreed upon method.

Continued coverage shall end on the earlier of the following dates:

- For a Dependent child, the date coverage would otherwise end as described in Section 4: When Coverage Ends;
- The date the Group ceases to provide Benefits to its employees under a group contract;
- The date on which the Covered Person becomes eligible for hospital, medical, or surgical benefits under an insured or self-insured group health benefit program or plan, other than the group contract, that is written on an expense-incurred basis or is with a health maintenance organization;

- The date the Covered Person accepts hospital, medical, or surgical coverage under a non-group contract of policy that is written on an expense-incurred basis or is with a health maintenance organization;
- The date the Covered Person becomes entitled to benefits under Title XVIII of the Social Security Act;
- For an Enrolled Dependent spouse, the date the Enrolled Dependent spouse remarries; or
- The date the Covered Person elects to end coverage. In order to end coverage, the Subscriber and Enrolled Dependent spouse must jointly sign a termination statement or the Subscriber must provide the Group with a signed and sworn affidavit verifying all facts in the termination statement.

Continuation of Coverage under State Law Due to the Subscriber's Voluntary or Involuntary Termination

Covered Persons whose coverage under the Policy would otherwise end due to the Subscriber's voluntary or involuntary termination from employment are entitled to continue coverage as described in this section. In order for a Covered Person to continue coverage, the Subscriber must have been continuously covered under the Policy (or a predecessor group policy with the same Group) for a period of at least 3 months prior to the voluntary or involuntary termination of employment and the Enrolled Dependent must have been covered under the Policy prior to the voluntary or involuntary termination of employment.

If a Covered Person wishes to continue coverage, he or she must request that the Group provide an election notification form. Within in 14 days of the receipt of the request, the Group will deliver or send by first-class mail an election notification form. Continuation coverage must be elected within 45 days of the date of the voluntary or involuntary termination from employment and the Covered Person must make any required payment for coverage to the Group. The Continuation coverage will be provided without evidence of insurability or additional waiting periods. The Continuation coverage will be identical to the coverage offered under the group contract to similarly situated individuals for whom there has not been a change in status.

Continued coverage shall end on the earlier of the following dates:

- Eighteen (18) months after the date continuation coverage began;
- The date coverage ends for failure to make timely payment of the Premium;
- The date the Group ceases to provide Benefits to its employees under a group contract;
- The date the Covered Person becomes eligible for hospital, medical, or surgical benefits under an insured of self-insured group health benefit program or plan, other than the group contract, that is written on an expense-incurred basis or is with a health maintenance organization;
- The date the Covered Person accepts hospital, medical, or surgical coverage under a non-group contract or policy that is written on an expense-incurred basis or is with a health maintenance organization;
- The date the Covered Person becomes entitled to benefits under *Title XVIII of the Social Security Act*;
- The date the Covered Person elects to end coverage.

Section 5: How to File a Claim

How Are Covered Dental Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Dental Care Services. If a Network provider bills you for any Covered Dental Care Service, contact us. However, you are required to meet any applicable deductible and to pay any required Co-payments and Co-insurance to a Network provider. You will also be responsible for any charges that are not covered by the Policy to your Dental Provider at the time of service, or when you receive a bill from the provider.

Providers have 180 days from the date a covered service is rendered to submit a claim for reimbursement.

How Are Covered Dental Care Services from an Out-of-Network Provider Paid?

When you receive Covered Dental Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

We do not require that you complete a claim form or that you provide a separate notice of claim prior to submitting your request for payment of Benefits; however, you must file the claim in a format that contains all of the information we require, as described below.

You have up to a year from the date of service to submit a request for payment of Benefits. Failure to furnish the request for payment within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the request within the required time and the claim was submitted within one year after the date of service. If you are legally incapacitated, the time frame for submitting a claim is suspended until legal capacity has been regained.

Providers have 180 days from the date of a covered service is rendered to submit a claim for payment.

Required Information

We do not require that you complete a claim form or that you provide a separate notice of claim prior to submitting your request for payment of Benefits; however when you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider(s) including a complete dental chart showing extractions, fillings or other Dental Care Services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports, as applicable.
- Casts, molds or study models, as applicable.
- An itemized bill which includes the CDT codes or a description of each charge.
- The date the dental disease began.

- A statement indicating either that you are, or you are not, enrolled for coverage under any other dental plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at Claims Department, P.O. Box 30978, Salt Lake City, UT 84130 or by fax to 248-733-6060. If you would like to use a claim form, you may access a form on the Internet at www.myuhc.com or call us at 1-800-445-9090 and a claim form will be provided to you.

Payment of Benefits

We will pay Benefits within 30 days after we receive your request for payment that includes all required information. If a Subscriber provides written authorization to allow this, all or a portion of any Allowed Amounts due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

We may refuse to directly reimburse an out-of-Network provider under an assignment of Benefits if:

- We receive notice of the assignment of Benefits after we have paid Benefits to the Covered Person.
- We, due to an inadvertent administrative error, have previously paid the Covered Person.
- You withdraw the assignment of Benefits before we paid the Benefits to the out-of-Network provider; or
- You paid the out-of-Network provider the amount due at the time of your service.

You do not have the right to bring any legal proceeding or action against us within 60 days of the date you submit your request for payment as directed above or after the expiration of 3 years after the written proof of loss is required to be furnished.

In addition, if a child has coverage through an insuring parent, we will pay Benefits to the non-insuring parent, health care provider, or the *Maryland Department of Health* if the non-insuring parent incurs expenses for the dental care provided to the child.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Contact Customer Service at 1-800-445-9090. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Contact Customer Service at 1-800-445-9090. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

Post-service Claims

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

Pre-service Requests for Benefits

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

Adverse Decisions, Adverse Decision Grievances and Adverse Decision Complaints

Defined Terms

For the purpose of this Section, the following terms have the following meanings:

- "Adverse decision" is our determination that a proposed or delivered Covered Health Service which would otherwise be covered under the Policy is not or was not, appropriate or efficient, and may result in non-coverage of the health service.
- "Adverse decision complaint" is a protest filed with the Insurance Commissioner involving an adverse decision or grievance decision concerning a Covered Person.
- "Adverse decision grievance" means a protest by you, your representative, or your health care provider on your behalf with us through our internal grievance process regarding an adverse decision.
- "Complaint" is a protest filed with the Insurance Commissioner that is either; a) an adverse decision complaint, or b) a complaint as allowed under the provision entitled *Complaints* below.
- "Grievance decision" is a final determination by us that arises from an adverse decision grievance filed with us under our internal adverse decision grievance process regarding an adverse decision.

- "Health Advocacy Unit" means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.
- "Health care provider" means a Hospital, or an individual who is licensed or otherwise authorized in the State of Maryland to provide health care services in the ordinary course of working or practice of a profession and is a treating provider of a Covered Person.
- "Your representative" means an individual who has been authorized by you to file a grievance or a complaint on your behalf.

Notice Requirements

All notification requirements provided to you, your representative, and/or your health care provider as described in this Section will be provided in a culturally and linguistically appropriate manner and will be provided within 30 calendar days after the appeal decision has been made.

Complaints

You, your representative, or your health care provider filing a complaint on a your behalf, may file a complaint with the Commissioner without first filing an adverse decision grievance with us and receiving a grievance decision if:

- We waive the requirement that our internal grievance process be exhausted before filing a complaint with the Commissioner;
- We have failed to comply with any of the requirements of the internal grievance process as described in this section;
- You, your representative, or your health care provider provides sufficient information and supporting documentation in the complaint that demonstrates a compelling reason for the complaint; or
- Your complaint is based on one of the exceptions as described below under *Internal Adverse Decision Grievance Process*.

Internal Adverse Decision Grievance Process

Under the law, you must exhaust our internal adverse decision grievance process before you file an adverse decision complaint with the Insurance Commissioner, unless the adverse decision involves an urgent condition for which services have not already been rendered, or is described above under Complaints, or unless it is under one of the other circumstances outlined below. For retrospective denials (denials on health services which have already been rendered), a compelling reason may not be shown. If the adverse decision by us involves an urgent medical condition for which services have not been rendered, you may address your complaint directly to the Insurance Commissioner without first directing it to us.

Adverse Decisions

We will not make an adverse decision retrospectively regarding preauthorized or approved Covered Health Services delivered to a Covered Person, unless such preauthorization or approval was based on fraudulent, intentionally misrepresented, or omitted information. Such omitted information must have been critical requested information regarding the Covered Health Services whereby the preauthorization or approval for such Covered Health Services would not have been approved if the requested information had been received.

For non-Emergency cases, if we render an adverse decision, a notice of this adverse decision will be verbally communicated to you, your representative, or your health care provider.

We will document the adverse decision in writing after we have provided the verbal communication of the adverse decision as described above.

Written notification of the adverse decision will be sent to you, your representative, and your health care provider within five working days after the adverse decision has been made.

For Emergency case adverse decisions timeframes, see below under the provision entitled *Expedited Review in Emergency Cases*.

The adverse decision will be accompanied by a *Notice of Adverse Decision* attachment. This Notice will include the following information:

- Details concerning the specific factual basis for the denial in clear, understandable language;
- The specific criteria or guidelines on which the decision is based;
- The name, business address and direct telephone number of the Medical Director who made the decision;
- Written details of our internal adverse decision grievance process and procedures;
- The right for you, your representative, or your health care provider on your behalf, to file an adverse decision complaint with the Insurance Commissioner within four months of receipt of our adverse grievance decision;
- The right for you, your representative, or your health care provider on your behalf, to file an adverse decision complaint with the Insurance Commissioner without first filing an adverse decision grievance with us if you, your representative, or your health care provider acting on your behalf can demonstrate a compelling reason to do so.
- The Insurance Commissioner's address, telephone number and fax number; and
- The information shown below regarding assistance from the Health Advocacy Unit.

Adverse Decision Grievances

If you have received an adverse decision, you, your representative, or your health care provider on your behalf, have the right to file an adverse decision grievance with us. The following conditions apply to adverse decision grievance filings:

- The adverse decision grievance may be filed by you, your representative, or your health care provider on your behalf, with us within 60 days of receipt of our adverse decision letter unless the adverse decision is a retrospective denial in which case you have up to 180 days from the date of receipt to file an adverse decision grievance.
- For prospective denials (denials on health services that have not yet been rendered), we will render a grievance decision in writing within 30 working days after the filing date, unless it involves an emergency case as explained below. The "filing date" is the earlier of five days after the date the adverse decision grievance was mailed or the date of receipt. Unless written permission has been given per the fourth bulleted item below, you, your representative, or your health care provider on your behalf, have the right to file an adverse decision complaint with the Insurance Commissioner, if you have not received our grievance decision on or before the 30th working day after the filing date.
- For retrospective denials (denials on health services that have already been rendered), we will render a grievance decision within 45 working days after the filing date. Unless written permission has been given you, your representative, or your health care provider on your behalf, have the right to file an adverse decision complaint with the Insurance Commissioner (see below), if you have not received our grievance decision on or before the 45th working day after the filing date.

- With written permission from you, your representative, or your health care provider on your behalf, the time frame within which we must respond can be extended up to an additional 30 working days.
- If we need additional information in order to review the case, we will notify you, your representative and/or your health care provider within five working days after the filing date. We will assist you, your representative, or the health care provider in gathering the necessary medical records without further delay. If no additional information is available or is not submitted to us, we will render a decision based on the available information.
- Except as described under the first two bullets in the *Complaints* provision above, for retrospective denials, you, your representative, or your health care provider on your behalf, must file an adverse decision grievance with us before filing an adverse decision complaint with the Insurance Commissioner, as described in the Assistance From Health Education and Advocacy Unit provision below.
- Notice of our grievance decision may be verbally communicated to you, your representative, or your health care provider. Written notification of our grievance decision will be sent to you, your representative and any health care provider who filed an adverse decision grievance on your behalf within five working days after the grievance decision has been made. If we uphold the adverse determination, the denial notification will include a *Notice of Grievance Decision*. This *Notice* will include the information in the bulleted items under *Adverse Decision* above. This notice will also include a statement that the Health Advocacy Unit is available to assist you or your representative in filing a complaint with the Commissioner.
- If any new or additional evidence is relied upon or generated by us during the determination of the adverse decision grievance, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.
- For prospective denials, you, your representative, or your health care provider on your behalf, may file an adverse decision complaint with the Insurance Commissioner (see below) without first filing an adverse decision grievance with us, if you, your representative, or your health care provider can demonstrate that the adverse decision concerns a compelling reason to do so. A "Compelling reason" means to show that a potential delay in receipt of a health care service until after the Covered Person or health care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, the Covered Person remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Covered Person to be in danger to self or others or the Covered Person continuing to experience severe withdrawal symptoms. A Covered Person is considered to be in danger to self or others if the Covered Person is unable to function in activities of daily living or care for self without imminent dangerous consequences.

Expedited Review in Emergency Cases

In emergency cases, you may request an expedited review of an adverse decision. An "emergency case" is a case involving an adverse decision of proposed health services which are necessary to treat a condition or illness that, without immediate medical attention, would seriously jeopardize the life or health of the Covered Person, or his or her ability to regain maximum function, or would cause the Covered Person to be in danger to self or others, or would cause the member to continue using intoxicating substances in an imminently dangerous manner.

The procedure listed below will be followed:

- If the health care provider filed the adverse decision grievance, he or she will determine whether the basis for an emergency case or expedited review exists. If the Covered Person, or the Covered Person's representative, filed the adverse decision grievance, we, in consultation with the health care provider, will determine whether the basis for an emergency case or expedited review exists. In either case, the determination will be based on the above definition of "emergency case".

- We will render a verbal grievance decision to an adverse decision grievance filed by you, your representative, or your health care provider on your behalf, within 24 hours of the date a grievance is filed with us. Within one day after the verbal grievance decision has been communicated, we will send notice in writing of any adverse decision grievance to you, your representative, and if applicable, your health care provider. If we need additional information in order to review the case, we will verbally inform you, your representative and/or your health care provider, and will assist with procuring the additional information. If we do not render a grievance decision within 24 hours, you, your representative, or your health care provider may file an adverse decision complaint directly with the Insurance Commissioner. If we uphold our decision to deny coverage for the Covered Health Services, we will send you, your representative and/or your health care provider the grievance decision in writing within one day of the verbal notification. The *Notice of Grievance Decision* will include the information specified for the *Notice of Adverse Decision* above and will include that the Health Advocacy Unit is available to assist you or your representative in filing a complaint with the Commissioner.

Assistance From the Health Education and Advocacy Unit

The Health Advocacy Unit is available to assist you or your representative with filing an adverse decision grievance under our internal adverse decision grievance process and assist you or your representative in mediating a resolution of our adverse decision. NOTE: The Health Advocacy Unit is not available to represent or accompany you or your representative during the proceedings. The Health Advocacy Unit may be reached at:

Health Education and Advocacy Unit

Consumer Protection Division

Office of the Attorney General

200 St. Paul Place, 16th Floor

Baltimore, Maryland 21202

410-528-1840 or 1-877-261-8807 (toll free)

Fax number: 410-576-6571

TTY: 1-800-735-2258

E-mail: consumer@oag.state.md.us

Medical Directors

Our Medical Directors who are responsible for adverse decisions and grievance decisions may be reached at:

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

301-762-8205/ 1-800-544-2853

Adverse Decision Complaints to the Insurance Commissioner

Within four months after receiving our *Notice of Grievance Decision*, or under the circumstances described above in the Complaints provision, you, your representative or your health care provider on your behalf, may submit an adverse decision complaint to the Insurance Commissioner at:

Maryland Insurance Administration

Appeals and Grievance Unit

200 St. Paul Place, Suite 2700

Baltimore, Maryland 21202

1-800-492-6116 or 410-468-2000

TTY: 1-800-735-2258

Fax Number 410-468-2270

When filing a complaint with the *Insurance Commissioner*, you or your representative will be required to authorize the release of any medical records of the Covered Person that may be required to be reviewed for the purpose of reaching a decision on the complaint.

The Health Advocacy Unit is available to assist you or your representative in filing a complaint with the *Insurance Commissioner*.

Health Education and Advocacy Unit

200 St. Paul Place, 16th Floor

Baltimore, Maryland 21202

Telephone number: (410) 528-1840

Fax number: (410) 576-6571

TTY: 1-800-735-2258

E-mail: consumer@oag.state.md.us

The *Insurance Commissioner* will make a final decision on a complaint as follows:

- For an emergency case, written notice of the *Insurance Commissioner's* final decision will be sent to the Covered Person, the Covered Person's representative and/or the health care provider within one day after the *Insurance Commissioner* has given verbal notification of the final decision.
- For an adverse decision complaint involving a pending health service, written notice of the *Insurance Commissioner's* final decision will be sent to he Covered Person, the Covered Person's representative and/or the health care provider within 45 days after the adverse decision complaint is filed.
- For an adverse decision complaint involving a retrospective denial of health services already provided, written notice of the *Insurance Commissioner's* final decision will be sent to the Covered Person, the Covered Person's representative and/or the health care provider within 45 days after the adverse decision complaint is filed.

Except for emergency cases, the time periods above for notification may be extended if additional information is necessary in order for the *Insurance Commissioner* to render a final decision, or if it is necessary to give priority to adverse decision complaints regarding pending health services.

Assistance from State Agencies

Governmental agencies are available to assist you with complaints that are not a result of an adverse decision as described above.

For quality of care issues and health care insurance complaints, contact the *Consumer Complaint & Investigation* at:

Consumer Complaint & Investigation

Life and Health

Maryland Insurance Administration

200 St. Paul Place, Suite 2700

Baltimore, Maryland 21202

Telephone number: 1-800-492-6116

Fax number: (410) 468-2270 or (410) 468-2260

TTY: 1-800-735-2258

For assistance in resolving a billing or payment dispute with the Company or a provider, contact the Health Advocacy Unit at:

Office of the Attorney General

Health Education and Advocacy Unit

200 St. Paul Place, 16th Floor

Baltimore, Maryland 21202

Telephone number: (410) 528-1840

Fax number: (410) 576-6571

TTY: 1-800-735-2258

E-mail: consumer@oag.state.md.us

Coverage and Appeal Decisions

For the purpose of this section, the following terms have the following meanings:

- "Appeal" means a protest filed by a Covered Person, a Covered Person's representative or a health care provider with us under our internal appeal process regarding a coverage decision concerning a Covered Person.
- "Appeal decision" means a final determination made by us that arises from an appeal filed with us under our appeal process regarding a coverage decision concerning a Covered person.
- "Coverage decision" means:
    - an initial determination by us or our representative that results in non-coverage of a health care service;
    - a determination by us that an individual is not eligible for coverage under the Policy;
    - any determination by us that results in the rescission of an individual's coverage under the Policy.

    A coverage decision includes a nonpayment of all or any part of a claim.

    A coverage decision does not include:

        - an adverse decision as described above; or
        - a pharmacy inquiry.

- "Health Advocacy Unit" means the *Health Education and Advocacy Unit* in the *Division of Consumer Protection of the Office of the Attorney General.*
- "Pharmacy inquiry" means an inquiry submitted by a pharmacist or pharmacy on behalf of a Covered Person to us or a pharmacy benefits manager at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary, if available, under the Policy.
- "Your representative" means an individual who has been authorized by you to file an appeal or a complaint on your behalf.

Within thirty (30) calendar days after a coverage decision has been made, we will send a written notice of the coverage decision to you, your representative (if any) and your treating health care provider. Notice of the coverage decision will include the following:

- Details, in clear, understandable language, the specific factual basis for the decision;
- The right for you, your representative, or a health care provider acting on your behalf, to file an appeal with us;
- The right for you, your representative, or a health care provider acting on your behalf to file a complaint with the Insurance Commissioner without first filing an appeal with us, if the coverage decision involves an urgent medical condition for which care has not been rendered;
- The Insurance Commissioner's address, telephone number and fax number;
- An explanation that the Health Advocacy Unit is available to assist you or your representative in both mediating and filing an appeal under our internal appeal process; and
- The address, telephone number, facsimile number and electronic mail address of the Health Advocacy Unit.

If a coverage decision results in non-coverage of a health care service including non-payment of all or any part of your claim, you, your representative, or your health care provider acting on your behalf, have a right to file an appeal within one hundred eighty (180) calendar days of receipt of the coverage decision. The appeal may be submitted verbally or in writing and should include any information you, your representative or a health care provider acting on your behalf believe will help us review your appeal. You, your representative or a health care provider acting on your behalf may call the phone number listed on your identification card to verbally submit your appeal. Send the written appeal to: Customer Support Group, P.O. Box 933, Frederick, MD 21705. We will render a final decision in writing to you, your representative and your health care provider acting on your behalf within 60 working days after the date on which the appeal is filed. Within thirty (30) calendar days after the appeal decision has been made, we will send you, your representative and your health care provider acting on your behalf, a written notice of the appeal decision.

Notice of an appeal decision will include the following:

- Details concerning the specific factual basis for the decision in clear, understandable language;
- The right for you, your representative, or a health care provider acting on your behalf, to file a complaint with the *Insurance Commissioner* within four months of receipt of our appeal decision;
- The *Insurance Commissioner's* address, telephone number and fax number;
- A statement that the Health Advocacy Unit is available to assist you in filing a complaint with the Commissioner; and
- The information shown below regarding assistance from the Health Advocacy Unit.

If you are dissatisfied with the outcome of the appeal, you, your representative or a health care provider acting on your behalf may file a complaint with the Life and Health Complaint Unit, Maryland Insurance

Administration, within four months after receipt of the appeal decision. You, your representative or a health care provider acting on your behalf may contact the Life and Health Complaint Unit, Maryland Insurance Administration, at 200 St. Paul Place, Suite 2700, Baltimore, MD 21202, phone (410) 468-2000, toll free (800) 492-6116 or facsimile (410) 468-2260.

The Insurance Commissioner may request that you, your representative or a health care provider acting on your behalf whom filed the complaint, to sign a consent form authorizing the release of your medical records to the Insurance Commissioner or the Insurance Commissioner's designee that are needed in order to make a final decision on the complaint.

You, your representative, or a health care provider acting on your behalf may contact the Health Advocacy Unit at:

Health Education Advocacy Unit

Consumer Protection Division

Office of the Attorney General

200 St. Paul Place, 16th Floor

Baltimore, MD 21202

Telephone: 410/528-1840 or toll free at 1-877/261-8807; Fax#: 410/576-6571

Email: consumer@ oag.state.md.us

Website address: www.oag.state.md.us

The Health Advocacy Unit can help you, your representative or a health care provider acting on your behalf prepare an appeal to file under our internal appeal procedure. That unit can also attempt to mediate a resolution to your dispute. The Health Advocacy Unit is not available to represent or accompany you or your representative during any proceeding of the internal appeal process.

Additionally, you, your representative or a health care provider acting on your behalf may file a complaint with the *Life and Health Complaint Unit, Maryland Insurance Administration*, without having to first file an appeal with us if (1) we have denied authorization for a health service not yet provided to you, and (2) you or the health care provider gives sufficient information and supporting documentation in the complaint that demonstrates an urgent medical condition exists.

"Urgent medical condition" means a condition that satisfies either of the following:

- A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on our behalf, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
    - Placing the Covered Person's life or health in serious jeopardy;
    - The inability of the Covered Person to regain maximum function;
    - Serious impairment to bodily function;
    - Serious dysfunction of any bodily organ or part; or
    - The Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be a danger to self or others; or
- A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of the Covered Person's medical condition, would subject the Covered Person to

severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits* (*COB*) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan**. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan**. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

Definitions

For purposes of this section, terms are defined as follows:

A. **Plan**. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: individual intensive care policies, hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

B. **This Plan**. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. **Order of Benefit Determination Rules**. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. **Allowable Expense**. Allowable Expense is a health care expense, including deductibles, co-insurance and co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

   The following are examples of expenses or services that are not Allowable Expenses:

   1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

   2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

   3. If a person is covered by two or more 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.

   4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

   5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. **Closed Panel Plan**. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent**. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

What Are the Rules for Determining the Order of Benefit Payments?

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan**. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care

coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee**. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage**. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage**. The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the

amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We 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.

Does This Plan Have the Right of Recovery?

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

How Are Benefits Paid When This Plan is Secondary to Medicare?

If This Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits.

Section 8: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We do not provide dental care services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's Policy will cover or pay for the dental care that you may receive. The Policy pays for Covered Dental Care Services, which are more fully described in this *Certificate*.
- The Policy may not pay for all dental care services or materials you or your Dental Provider may believe are needed. If the Policy does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

What Is Our Relationship with Providers and Groups?

The relationships between us and Network Dental Providers and Groups are solely contractual relationships between independent contractors. Network Dental Providers and Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network Dental Providers or the Groups.

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

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Group's Policy. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Group's Policy.

The Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of when the Policy ends.

When the Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Groups?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own Dental Provider.
- Paying, directly to your Dental Provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any deductible and any amount that exceeds the Allowed Amount.
- Paying, directly to your Dental Provider, the cost of any non-Covered Dental Care Service.
- Deciding if any provider treating you is right for you. This includes Network Dental Providers you choose and Dental Providers that they refer.
- Deciding with your Dental Provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy after it has been in force for two years unless it is a fraudulent statement.

Who Interprets Benefits and Other Provisions under the Policy?

We have the final authority to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Covered Dental Care Services* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may assign this authority to other persons or entities that provide services in regard to the administration of the Policy.

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

Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the

nature of the services they provide may be changed from time to time as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we have the right, as we determine and without your approval, to change, interpret, withdraw or add Benefits or end the Policy.

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

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning dental care services when any of the following apply:

- Needed to put in place and administer the terms of the Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your dental records or billing statements you may contact your Dental Provider. Providers 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, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Dental Provider of our choice examine you at our expense.

Is Workers' Compensation Affected?

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

Subrogation and Reimbursement

We have the right to subrogation and reimbursement. References to "you" or "your" in this *Subrogation and Reimbursement* section shall include you, your Estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when we have paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that we have paid that are related to the Sickness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to us 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- Your employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.

- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    - Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
    - Providing any relevant information requested by us.
    - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or injuries.
    - Making court appearances.
    - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
    - Complying with the terms of this section.

    Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to you or your representative not cooperating with us. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by us may also be considered to be Benefits advanced.

- If you receive any payment from any party as a result of Sickness or Injury, and we allege some or all of those funds are due and owed to us, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Policy (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by us to enforce its reimbursement rights. Proceeds received by us will be reduced by a pro rata share of the court costs and legal fees incurred by the Covered Person applicable to the portion of the settlement returned to us.
- Our right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from us, you agree to assign to us any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits we have paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize our right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- We may, at our option, take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's name, which does not obligate us in any way to pay you part of any recovery we might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Policy is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse us, without our written approval.
- We have the final authority to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death our right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Policy, the provisions of this section continue to apply, even after you are no longer covered.

- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, we may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Policy. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- We and all Administrators administering the terms and conditions of the Policy's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of our final authority to (1) construe and enforce the terms of the Policy's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to us.

When Do We Receive Refunds of Overpayments?

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Policy. If the refund is due from a person or organization other than you, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. If you want to bring a legal action against us you must do so within three years of the date written proof of loss is required to be furnished or you lose any rights to bring such an action against us.

What Is the Entire Policy?

The Policy, this *Certificate*, the *Schedule of Covered Dental Care Services*, the Group's *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Group.

A change in the Policy is not valid:

- Until approved by an executive officer of the company, and
- Unless the approval is endorsed on the Policy or attached to the Policy.

Section 9: Defined Terms

Allowed Amounts - Allowed Amounts for Covered Dental Care Services, incurred while the Policy is in effect, are determined as stated below:

A. For Network Benefits, when Covered Dental Care Services are received from Network Dental Providers, Allowed Amounts are our contracted fee(s) for Covered Dental Care Services with that Dental Provider.

B. For out-of-Network Benefits, when Covered Dental Care Services are received from out-of-Network Dental Providers, Allowed Amounts are our contracted fee(s) for Covered Dental Care Services with a Network Dental Provider in the same geographic area.

Amendment - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - the total of the Allowed Amount you must incur for Covered Dental Care Services in a calendar year before we will begin paying for Network or out-of-Network Benefits in that calendar year. It does not include any amount that exceeds Allowed Amounts. The *Schedule of Covered Dental Care Services* will tell you if your plan is subject to an Annual Deductible.

Benefits - your right to payment for Covered Dental Care Services that are available under the Policy.

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 care 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.

Co-insurance - the charge, stated as a percentage of the Allowed Amount, that you are required to pay for certain Covered Dental Care Services.

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

Consumer Max Multiplier - a provision that allows the unused portion of a Maximum Benefit to be carried over to the next calendar year if specified requirements are met.

Co-payment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Dental Care Services.

Please note that for Covered Dental Care Services, you are responsible for paying the lesser of the following:

- The Co-payment.
- The Allowed Amount.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Dental Care Service(s) or Dental Procedures - dental care services, including supplies or materials, which we determine to be all of the following:

- Necessary.
- Treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

- Described as a Covered Dental Care Service in this *Certificate* under *Section 1: Covered Dental Care Services* and in the *Schedule of Covered Dental Care Services*.
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Covered Person - the Subscriber or a Dependent, but this term applies only while the person is enrolled under the Policy. We use "you" and "your" in this *Certificate* to refer to a Covered Person.

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

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. To be eligible for Coverage under the Policy, a Dependent must reside within the United States. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A grandchild who is unmarried and a Dependent of the Subscriber or the Subscriber's spouse.
- 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.
- A child for whom dental care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A Dependent includes an unmarried child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month following the date the child reaches age 26.

The Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has a Domestic Partnership.

Domestic Partnership - a relationship between a Subscriber and one other person of the opposite or same sex. All of the following requirements apply to both persons. They must:

- Not be related by blood or a degree of closeness that is prohibited by law in the state of residence.

- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Share the same permanent residence and the common necessities of life.
- Be at least 18 years of age.
- Be mentally able to consent to contract.
- They must be financially interdependent.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Policy. An Eligible Person must live within the United States.

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 under the Policy.

Experimental or Investigational Service(s) - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- 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.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- 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.
- Pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

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

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Policy.

Maximum Benefit - the maximum amount paid for Covered Dental Care Services during a calendar year for you under the Policy or any Policy, issued by us to the Enrolling Group, that replaces the Policy. The Maximum Benefit is stated in the *Schedule of Covered Dental Care Services*.

Maximum Policy Benefit - the maximum amount paid for Network and out-of-Network Benefits during the entire period of time that you are covered under the Policy or any Policy, issued by us to the Enrolling

Group, that replaces the Policy. The Maximum Policy Benefit is stated in the *Schedule of Covered Dental Care Services*.

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

Natural Tooth - sound natural teeth are defined as teeth that are free of any pathological, functional or structural disorders at the time of injury and not having had any restorative treatment including, but not limited to fillings, root canals, crowns, caps and orthodontia in place at the time of trauma.

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

A. needed to meet your basic dental needs; and

B. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Care 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 us; and

D. consistent with the diagnosis of the condition; and

E. required for reasons other than the convenience of you or your Dental Provider; 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 its 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 Dental Provider 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 Care Service as defined in this *Certificate*. The definition of Necessary used in this *Certificate* relates only to Coverage and differs from the way in which a Dental Provider engaged in the practice of dentistry may define Necessary.

Network - when used to describe a provider of dental care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Dental Care Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Dental Care Services, but not all Covered Dental Care Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Dental Care Services and products included in the

participation agreement and an out-of-Network provider for other Covered Dental Care Services and products. The participation status of providers will change from time to time.

Dental members who do not have access to a participating provider within 30 miles of their home address or place of employment will be able to see a physician of their choice for dental preventive examination. Additionally, referrals to specialists or non-physician specialists will be provided to the member in the event their diagnosis necessitates this type of care. The member will be reimbursed as in-network coverage according to their dental benefit plan.

Network Benefits - the description of how Benefits are paid for Covered Dental Care Services provided by Network providers. The *Schedule of Covered Dental Care Services* will tell you if your plan offers Network Benefits and how Network Benefits apply.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Policy. The Group sets the period of time that is the Open Enrollment Period.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Dental Care Services provided by out-of-Network providers. The *Schedule of Covered Dental Care Services* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Group that includes all of the following:

- *Group Policy*.
- *Certificate*.
- *Schedule of Covered Dental Care Services*.
- Group *Application*.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Group.

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

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

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

Rider - any attached written description of additional Covered Dental Care Services not described in this *Certificate*. Covered Dental Care Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

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

Schedule of Covered Dental Care Services

How Do You Access Benefits?

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

You can choose to receive Network Benefits or out-of-Network Benefits.

Network Dental Providers

We have arranged with certain Dental Providers to participate in a Network. These Network Dental Providers have agreed to discount their charges for Covered Dental Care Services and supplies.

If Network Dental Providers are used, the amount of Covered expenses for which you are responsible will generally be less than the amount owed if out-of-Network Dental Providers had been used. The Co-insurance level remains the same whether or not Network Dental Providers are used. However, because the total charges for Covered expenses may be less when Network Dental Providers are used, the portion that you owe will generally be less.

Directory of Network Dental Providers

A Directory of Network Dental Providers will be made available. You may access the Directory of Network Dental Providers online at www.myuhc.com. You can also call customer service to determine which Dental Providers participate in the Network at 1-800-445-9090.

Network and out-of-Network Benefits

This *Schedule of Covered Dental Care Services* describes both benefit levels available under the Policy.

Network Benefits

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

The only exception is if you need Emergency care and you are out of your service area or are unable to contact your Network general Dental Provider. In this situation, Emergency care will be covered as a Network Benefit and you will not be responsible for greater out-of-pocket expenses than if you had attended a Network Dental Provider. You must submit appropriate reports and x-rays.

When Dental Care Services are received from an out-of-Network Dental Provider as a result of an Emergency, the Co-insurance will be the Network Co-insurance.

In the case of non-Emergency Orthodontic Services, seek care at the nearest Dental Provider. In this case, the Co-insurance will be the Network Co-insurance unless we can arrange for care by a Network Dental Provider.

Enrolling for Coverage under the Policy does not guarantee Dental Care Services by a particular Network Dental Provider on the list of Dental Providers. The list of Network Dental Providers is subject to change. When a Dental Provider on the list no longer has a contract with us, you must choose among remaining Network Dental Providers. You are responsible for verifying the Network participation status of your Dental Provider, prior to receiving such Dental Care Services.

If you fail to verify whether your treating Dental Provider's participation in the Network, and the failure results in non-compliance with our required procedures, Coverage of Network Benefits may be denied.

Coverage for Dental Care Services is subject to payment of the Premium required for Coverage under the Policy, satisfaction of any applicable deductible, and payment of the Co-insurance specified for any service and payment of the percentage of Allowed Amounts shown in this *Schedule of Covered Dental Care Services* and generally require you to pay less to the Dental Provider than out-of-Network Benefits. Network Benefits are determined based on the contracted fee for each Covered Dental Care Service. In no event will you be required to pay a Network Dental Provider an amount for a Covered Dental Care Service in excess of the contracted fee.

Network Benefits:

When Network Co-insurance is charged as a percentage of Allowed Amounts, the amount you pay for Dental Care Services from Network Dental Provider is determined as a percentage of the negotiated contract fee between us and the Dental Provider rather than a percentage of the Dental Provider's billed charge. Our negotiated rate with the Dental Provider is ordinarily lower than the Dental Provider's billed charge.

A Network Dental Provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network Dental Provider may charge you. However, these charges will not be considered Covered Dental Care Services and will not be payable by us.

Out-of-Network Benefits

Out-of-Network Benefits apply when you obtain Dental Care Services from out-of-Network Dental Providers.

Before you are eligible for Coverage of Dental Care Services obtained from out-of-Network Dental Providers, you must meet the requirements for payment of the applicable deductible stated below. Generally you are required to pay more than Network Benefits. Out-of-Network Dental Providers may request that you pay all charges when services are rendered. You must file a claim with us for reimbursement of Allowed Amounts.

We will reimburse an out-of-Network Dental Provider for a Covered Dental Care Service up to an amount equal to the contracted fee for the same Covered Dental Care Service received from a similarly situated Network Dental Provider. The actual charge made by an out-of-Network Dental Provider for a Covered Dental Care Service may exceed the contracted fee. As a result, you may be required to pay an out-of-Network Dental Provider an amount for a Covered Dental Care Service in excess of the contracted fee. In addition, when you obtain Covered Dental Care Services from an out-of-Network Dental Provider, you must file a claim with us to be reimbursed for Allowed Amounts.

Classes of Dental Benefits

Listed below are the class categories of Covered Dental Care Services. The table below will provide information on your specific Benefits and class of the dental care service. Any Covered Dental Care Service in one class can be shifted to another class.

Class I - Dental Benefits:

- Diagnostic Services
- Preventive Services
- Radiographs
- Space Maintainers

Class II - Dental Benefits:

- Adjunctive Services

- Endodontic Services
- Minor Restorative Services
- Oral Surgery Services
- Periodontic Services

Class III - Dental Benefits:

- Cosmetic Procedures
- Implants Procedures
- Major Restorative Services
- Prosthodontic Services
- Removable Dentures

Class IV - Dental Benefits:

- Orthodontic Services

BENEFIT DESCRIPTION & LIMITATION	**NETWORK CO-INSURANCE** is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	**OUT-OF-NETWORK CO-INSURANCE** is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
CLASS I **DIAGNOSTIC SERVICES** • **Except Cone beams**		
Bacteriologic Cultures	0%	0%
Viral Cultures	0%	0%
Intraoral Bitewing Radiographs Images Limited to 1 series of images per calendar year.	0%	0%
Panorex Radiographs Image Limited to 1 time per consecutive 36 months.	0%	0%
Oral/Facial Photographic Images Limited to 1 time per consecutive	0%	0%

BENEFIT DESCRIPTION & LIMITATION	**NETWORK CO-INSURANCE** is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	**OUT-OF-NETWORK CO-INSURANCE** is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
36 months.		
Cone Beam CT Capture and Interpretation with Limited Field of View - Less than One Whole Jaw Limited to 1 time every consecutive 60 months.	40%	40%
Cone Beam CT Capture and Interpretation with Field of View of One Full Dental Arch-Mandible Limited to 1 time every consecutive 60 months.	40%	40%
Cone Beam CT Capture and Interpretation with Field of View of One Full Dental Arch-Maxilla, With and Without Cranium Limited to 1 time every consecutive 60 months.	40%	40%
Cone Beam CT Capture and Interpretation with Field of View of Both Jaws, With and Without Cranium Limited to 1 time every consecutive 60 months.	40%	40%
Diagnostic Casts Limited to 1 time per consecutive 24 months.	0%	0%
Extraoral Radiographs Images Limited to 2 images per calendar year.	0%	0%
Intraoral - Complete Series of Radiograph Images Limited to 1 time per consecutive 36 months. Vertical bitewings	0%	0%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
cannot be billed in conjunction with a complete series.		
Intraoral Periapical Radiographs Image Limited to 8 images per calendar year.	0%	0%
Pulp Vitality Tests Limited to 1 charge per visit, regardless of how many teeth are tested.	0%	0%
Intraoral Occlusal Radiographs Image Limited to 2 images per 6 months.	0%	0%
Vertical Bitewings, 7-8 Radiograph Images Limited to 1 series of images per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series.	0%	0%
Periodic Oral Evaluation Limited to 2 times per consecutive 12 months.	0%	0%
Comprehensive Oral Evaluation Limited to new patients or 2 times per consecutive 12 months. Not covered if done in conjunction with other exams.	0%	0%
Limited or Detailed Oral Evaluation Limited to 2 times per consecutive 12 months. Only 1 exam is covered per date of	0%	0%

BENEFIT DESCRIPTION & LIMITATION	**NETWORK CO-INSURANCE** is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	**OUT-OF-NETWORK CO-INSURANCE** is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
service.		
Comprehensive Periodontal Evaluation - new or established patient Limited to 2 times per consecutive 12 months.	0%	0%
Oral Evaluation for a Patient under three Years of Age and Counseling Primary Caregiver Limited to 2 times per consecutive 12 months. Not covered if done in conjunction with other exams.	0%	0%
Teledentistry - synchronous; real-time encounter Limited to 2 times per consecutive 12 months.	0%	0%
Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review Limited to 2 times per consecutive 12 months.	0%	0%
Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures Limited to 1 time per consecutive 12 months.	0%	0%
CLASS I **PREVENTIVE SERVICES**		
Dental Prophylaxis Limited to 2 times per	0%	0%

BENEFIT DESCRIPTION & LIMITATION	**NETWORK CO-INSURANCE** is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	**OUT-OF-NETWORK CO-INSURANCE** is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
consecutive 12 months.		
Fluoride Treatments - child Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.	0%	0%
Sealants Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	0%	0%
Preventive Resin Restoration in a Moderate to High Caries Risk Patient - Permanent Tooth Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	0%	0%
Space Maintainers Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	0%	0%
Re-Cementation of Space Maintainers Limited to 1 per consecutive 6 months after initial insertion.	0%	0%
Removal of Fixed Space Maintainer	0%	0%
CLASS II		

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
MINOR RESTORATIVE SERVICES		
Amalgam Restorations Multiple restorations on one surface will be treated as a single filling.	10%	10%
Composite Resin Restorations - Anterior Multiple restorations on one surface will be treated as a single filling.	10%	10%
Gold Foil Restorations Multiple restorations on one surface will be treated as a single filling.	10%	10%
CLASS II **ENDODONTICS**		
Apexification Limited to 1 time per tooth per lifetime.	10%	10%
Apicoectomy Limited to 1 time per tooth per lifetime.	10%	10%
Retrograde Filling Limited to 1 time per tooth per lifetime.	10%	10%
Hemisection Limited to 1 time per tooth per lifetime.	10%	10%
Root Canal Therapy Limited to 1 time per tooth per lifetime. Dentist cannot charge	10%	10%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
retreatment codes on tooth treated for the first 12 months.		
Retreatment of Previous Root Canal Therapy Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	10%	10%
Root Resection/Amputation Limited to 1 time per tooth per lifetime.	10%	10%
Therapeutic Pulpotomy Limited to 1 time per primary or secondary tooth per lifetime.	10%	10%
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration) Limited to 1 per tooth per lifetime. Covered for anterior or posterior teeth only.	10%	10%
Pulp Caps - Direct/Indirect - excluding final restoration Not covered if utilized solely as a liner or base underneath a restoration.	10%	10%
Pulpal Debridement, Primary and Permanent Teeth Limited to 1 time per tooth per lifetime. Not covered on the same day as other endodontic services.	10%	10%
Pulpal Regeneration - (Completion of Regenerative Treatment in an Immature	10%	10%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Permanent Tooth with a Necrotic Pulp) does not include Final Restoration Limit 1 per tooth per lifetime.		
CLASS II **PERIODONTICS**		
Crown Lengthening Limited 1 per quadrant or site per consecutive 36 months.	10%	10%
Gingivectomy/Gingivoplasty Limited 1 per quadrant or site per consecutive 36 months.	10%	10%
Gingival Flap Procedure Limited 1 per quadrant or site per consecutive 36 months.	10%	10%
Osseous Graft Limited 1 per quadrant or site per consecutive 36 months.	10%	10%
Osseous Surgery Limited 1 per quadrant or site per consecutive 36 months.	10%	10%
Guided Tissue Regeneration Limited 1 per quadrant or site per consecutive 36 months.	10%	10%
Soft Tissue Surgery Limited 1 per quadrant or site per consecutive 36 months.	10%	10%
Surgical Revision Procedure Limited to 1 per quadrant or site per consecutive 36 months.	10%	10%

BENEFIT DESCRIPTION & LIMITATION	**NETWORK CO-INSURANCE** is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	**OUT-OF-NETWORK CO-INSURANCE** is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Periodontal Maintenance Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.	10%	10%
Full Mouth Debridement Limited to once per consecutive 36 months.	10%	10%
Provisional Splinting Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.	10%	10%
Scaling and Root Planing Limited to 1 time per quadrant per consecutive 24 months.	10%	10%
Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report Limited to 3 sites per quadrant or 12 sites total for refractory pockets or in conjunction with Periodontal Scaling and Root Planing.	10%	10%
CLASS II		

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
ORAL SURGERY		
Alveoloplasty	10%	10%
Biopsy Limited to 1 biopsy per site per visit.	10%	10%
Frenectomy/Frenuloplasty	10%	10%
Surgical Incision Limited to 1 per site per visit.	10%	10%
Removal of a Benign Cyst/Lesions Limited to 1 per site per visit.	10%	10%
Removal of Torus Limited to 1 per site per visit.	10%	10%
Root Removal, Surgical Limited to 1 time per tooth per lifetime.	10%	10%
Simple Extractions Limited to 1 time per tooth per lifetime.	10%	10%
Surgical Extraction of Erupted Teeth or Roots Limited to 1 time per tooth per lifetime.	10%	10%
Surgical Extraction of Impacted Teeth Limited to 1 per tooth per lifetime.	10%	10%
Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth	10%	10%

BENEFIT DESCRIPTION & LIMITATION	**NETWORK CO-INSURANCE** is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	**OUT-OF-NETWORK CO-INSURANCE** is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Limited to 1 per tooth per lifetime.		
Primary Closure of a Sinus Perforation Limited to 1 per tooth per lifetime.	10%	10%
Placement of Device to Facilitate Eruption of Impacted Tooth Limited to 1 time per tooth per lifetime.	10%	10%
Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report Limited to 1 time per tooth per lifetime.	10%	10%
Vestibuloplasty Limited to 1 time per site per consecutive 60 months.	10%	10%
Bone Replacement Graft for Ridge Preservation - per site Limited to 1 per site per lifetime. Not covered if done in conjunction with other bone graft replacement procedures.	10%	10%
Excision of Hyperplastic Tissue or Pericoronal Gingiva Limited to 1 per site per consecutive 36 months.	10%	10%
Appliance Removal (not by dentist who placed appliance) includes removal of arch bar Limited to once per appliance per lifetime.	10%	10%
Tooth Reimplantation and/or	10%	10%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Transplantation Services Limited to 1 per site per lifetime.		
CLASS II **ADJUNCTIVE SERVICES**		
Analgesia Covered when Necessary in conjunction with Covered Dental Care Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	10%	10%
Desensitizing Medicament	10%	10%
General Anesthesia Covered when Necessary in conjunction with Covered Dental Care Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	40%	40%
Local Anesthesia Not covered in conjunction with operative or surgical procedure.	40%	40%
Intravenous Sedation and Analgesia Covered when Necessary in conjunction with Covered Dental	40%	40%

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Care Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.		
Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report Limited to 1 per visit.	10%	10%
Occlusal Adjustment	10%	10%
Occlusal Guards Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.	10%	10%
Occlusal Guard Reline and Repair Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	10%	10%
Occlusion Analysis - Mounted Case Limited to 1 time per consecutive 60 months.	10%	10%
Emergency Palliative Treatment Covered as a separate benefit only if no other services, other than the exam and radiographs, were done on the same tooth during the visit.	0%	0%

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Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.) Not covered if done with exams or professional visit.	10%	10%
CLASS III **MAJOR RESTORATIVE SERVICES** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Coping Limited to 1 per tooth per consecutive 60 months. Not covered if done at the same time as a crown on same tooth.	40%	40%
Crowns - Retainers/Abutments Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	40%	40%
Crowns - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	40%	40%
Temporary Crowns - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore	40%	40%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes.		
Inlays/Onlays - Retainers/Abutments Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	40%	40%
Inlays/Onlays - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	40%	40%
Pontics Limited to 1 time per tooth per consecutive 60 months.	40%	40%
Retainer - Cast Metal for Resin Bonded Fixed Prosthesis Limited to 1 time per consecutive 60 months.	40%	40%
Pin Retention Limited to 2 pins per tooth; not covered in addition to cast restoration. Limited to 1 time per consecutive 60 months.	40%	40%
Post and Cores Covered only for teeth that have	40%	40%

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had root canal therapy.		
Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core Limited to 1 per consecutive 12 months. Limited to those performed more than 12 months after the initial insertion.	40%	40%
Protective Restoration Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.	40%	40%
Stainless Steel Crowns Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	40%	40%
CLASS III **FIXED PROSTHETICS** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Fixed Partial Dentures (bridges) Limited to 1 time per tooth per consecutive 60 months.	40%	40%
CLASS III **REMOVABLE PROSTHETICS** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial		

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
or supplemental placement.		
Full Dentures Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	40%	40%
Partial Dentures Limited to 1 per consecutive 60 months. No additional allowances for precision or semi precision attachments.	40%	40%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	40%	40%
Tissue Conditioning - Maxillary or Mandibular Limited to 1 time per consecutive 12 months.	40%	40%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	40%	40%
CLASS III **IMPLANTS** Replacement of implants, implant crowns, implant prostheses, and implant supporting structures (such as connectors) previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Implant Placement	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Limited to 1 time per tooth per consecutive 60 months.		
Implant Supported Prosthetics Limited to 1 time per tooth per consecutive 60 months.	50%	50%
Implant Maintenance Procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis Limited to 1 time per consecutive 12 months.	50%	50%
Repair Implant Supported Prosthesis, by report Limited to 1 per consecutive 6 months.	50%	50%
Abutment Supported Crown (titanium) or Retainer Crown for FPD - titanium Limited to 1 time per tooth per consecutive 60 months.	50%	50%
Repair Implant Abutment, by report Limited to 1 per consecutive 6 months.	50%	50%
Implant Removal, by report Limited to 1 time per tooth per consecutive 60 months.	50%	50%
CLASS III **COSMETIC**		
Labial Veneer (laminate) - Chairside Limited to 1 time per tooth per	40%	40%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
consecutive 60 months. Covered only when a filling cannot restore the tooth.		
Labial Veneer (resin laminate) - Laboratory Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	40%	40%
Labial Veneer (porcelain laminate) - Laboratory Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	40%	40%
CLASS IV **ORTHODONTICS** Orthodontic services are subject to the applicable Waiting Period, satisfaction of the Deductible and the orthodontic Deductible, and payment of any applicable Co-insurance.		
Orthodontic Services Services or supplies furnished by a Dentist to a Dependent under age 19 in order to diagnose or correct misalignment of the teeth or the bite. The extended coverage provision does not apply to orthodontic services.	50%	50%
Appliance Therapy, Fixed or Removable Limited to 1 time per consecutive 60 months. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Cephalometric Radiographic Image Limited to 1 per consecutive 12 months.	50%	50%

Covered Dental Care Services are subject to satisfaction of any applicable Deductibles, Maximum Benefits and payment of any Co-insurance as stated below.

Cost Share: Deductibles and Benefit Maximums

Deductible

Annual Deductible is $50 per Covered Person for Network Benefits and $50 per Covered Person for out-of-Network Benefits per calendar year.

The Annual Deductible will not exceed $150 for Network Benefits and $150 for out-of-Network Benefits for all Covered Persons in a family per calendar year.

The Annual Deductible does not apply to: DIAGNOSTIC SERVICES, PREVENTIVE SERVICES and ORTHODONTICS.

Maximum Benefit is $5,000 per Covered Person per calendar year.

The Maximum Benefit does not apply to: DIAGNOSTIC SERVICES and PREVENTIVE SERVICES.

Consumer Max Multiplier

If a Covered Person has claims for Covered Dental Care Services in a calendar year of less than $2,500 an additional $900 will be added to the Maximum Benefit in the next calendar year and an additional $100 will be added to the Maximum Benefit in the next calendar year when only Network Benefits are utilized up to a limit of $3,750 additional Maximum Benefit.

After the first calendar year following the Covered Person's Effective Date, the Maximum Benefit per Covered Person may be increased by the carry over amount if:

a.) the Covered Person has submitted a claim for an Allowed Amount incurred during the preceding calendar year; and

b.) the reimbursement for the Allowed Amount incurred in the preceding calendar year did not exceed the benefit threshold.

In each succeeding calendar year in which the reimbursement for Allowed Amounts does not exceed the benefit threshold, the Covered Person will be eligible for the carry over amount. The carry over amount can be accumulated from one calendar year to the next up to the maximum carry over amount unless:

a.) during any calendar year, Allowed Amounts are reimbursed in excess of the threshold. In this instance, there will be no additional carry over amount for the calendar year; or

b.) during any calendar year, no claims for Allowed Amounts incurred during the preceding calendar year are submitted. In this instance, there will be no carry over amount for the calendar year.

Eligibility for the carry over amount will be established or reestablished at the time for the first claim in a calendar year is received for Allowed Amounts incurred during the calendar year. In order to properly calculate the carry over amount, claims should be submitted timely.

You have the right to request review of prior carry over amount calculations. The request for review must be within 24 months from the date the carry over amount was established.

Maximum Policy Benefit

The Maximum Policy Benefit is $1,500 per Covered Person.

Maximum Policy Benefit applies to ORTHODONTICS.

All Dental Care Services and procedures follow the criteria specified in the *Current Dental Terminology* (*CDT*) listing as defined by the *American Dental Association*.

Language Assistance Services

We[1] provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-800-445-9090, or the toll-free member phone number listed on your dental plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-800-445-9090.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：1-800-445-9090。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-800-445-9090.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-445-9090 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-800-445-9090.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является Русский (Russian). Позвоните по номеру 1-800-445-9090.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-800-445-9090.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-800-445-9090.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-800-445-9090.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-800-445-9090.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue para 1-800-445-9090.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-800-445-9090.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-800-445-9090 an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。1-800-445-9090 にお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. تماس بگیرید 1-800-445-9090.

कृपा ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-800-445-9090

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-800-445-9090.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ(Khmer)សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-800-445-9090 ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-800-445-9090.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-800-445-9090 hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-800-445-9090.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά (Greek), υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε 1-800-445-9090.

ધ્યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વનિા મૂલ્યે પ્રાપ્ય છે.

કૃપા કરી 1-800-445-9090 પર કોલ કરો. TTY 711

Notice of Non-Discrimination

We[1] do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

UnitedHealthcare 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 or the toll-free member phone number listed on your dental plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m.

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

[1]For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

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, 2022

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, 2022

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 Health 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.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to get, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan due to a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act* (*COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 a day (subject to adjustment based on inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person

you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also get certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

ERISA Statement

If the Group is subject to *ERISA*, the following information applies to you.

Summary Plan Description

Name of Plan: AIMS Benefit Trust Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

AIMS Benefit Trust
890 Airport Park Road # 103
Glen Burnie, MD 21061
(410) 590-6590

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan, except to the extent the Plan Sponsor has assigned or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

Claims Fiduciary: UnitedHealthcare Insurance Company ("UnitedHealthcare," refer to your Certificate of Coverage for details on the legal entity that provides your coverage) is your Plan's Claims Fiduciary and has been assigned this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan.

Employer Identification Number (EIN): 52-1642161

Plan Number: 501

Plan Year: January 1 through December 31

Type of Plan: Health care coverage plan

Name, Business Address, and Business Telephone Number of Plan Administrator:

AIMS Benefit Trust
890 Airport Park Road # 103
Glen Burnie, MD 21061
(410) 590-6590

Type of Administration of the Plan: Your Plan is fully insured. Benefits are provided under a group insurance contract entered into between your Plan Sponsor and UnitedHealthcare. Claims for benefits are sent to UnitedHealthcare. Your employer and UnitedHealthcare share responsibility for administering the plan.

UnitedHealthcare
185 Asylum Street
Hartford, CT 06103-0450
877-294-1429

Person designated as Agent for Service of Legal Process: Plan Administrator

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made according to such discretionary authority shall be given deference and be legally binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

Source of Contributions and Funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

Method of Calculating the Amount of Contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Amendment or Termination of the Plan: Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.