UnitedHealthcare PPO Dental

UnitedHealthcare Insurance Company

Certificate of Coverage

FOR: AIMS Benefit Trust

DENTAL PLAN NUMBER : 3H145

ENROLLING GROUP NUMBER: 717578

EFFECTIVE DATE: January 1, 2019

Offered and Underwritten by

UnitedHealthcare Insurance Company

Dental Certificate of Coverage

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

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

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

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

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

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

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

Introduction to Your Certificate

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

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

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

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

How To Use This Certificate

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

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

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

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

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

However, this *Certificate* may be amended at any time by applicable state or Federal laws, rules and regulations. Such laws and the rules and regulations promulgated under them, when they are applicable, control and supersede this *Certificate*.

Dental Services Covered Under the Policy

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

A Dental Provider's participation status is his/her status as a Network or Non-Network Dental Provider. You must always verify the participation status of a Dental Provider prior to seeking services. From time to time, the participation status of a Dental Provider may change. You can verify the participation status by calling us and/or the Dental Provider. If necessary, we can provide assistance in referring you to Network Dental Providers.

Only Necessary Dental Services are Covered under the Policy. The fact that a 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 does not mean that the procedure or treatment is Covered under the Policy.

We have sole authority to interpret the benefits Covered under the Policy and the other terms, conditions, limitations and exclusions set out in the Policy and in making factual determinations related to the Policy and its benefits. We may, from time to time, delegate this authority to other persons or entities providing services in regard to the Policy.

We reserve the right to change, interpret, modify, withdraw or add benefits or terminate the Policy, as permitted by law, without your approval. No person or entity has any authority to make any oral changes or amendments to the Policy.

We may, in certain circumstances for purposes of overall cost savings or efficiency provide Coverage for services which would otherwise not be Covered. The fact that we do so in any particular case will not in any way be deemed to require us to do so in other similar cases.

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

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

Important Note About Services

We do not provide Dental Services or practice dentistry. Rather, we arrange for providers of Dental Services to participate in a Network. Network Dental Providers are independent practitioners and are not employees of the Company. We, therefore, make payment to Network Dental Providers through various types of contractual arrangements. These arrangements may include financial incentives to promote the delivery of dental care in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to Necessary Dental Services.

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

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

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

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

Identification (ID) Card

You should show your ID card every time you request Dental Services. If you do not show your ID card, the provider is unable to confirm eligibility and that you are Covered under a Policy issued by us and you may receive a bill for Network Benefits.

Contact Us

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

Dental Certificate of Coverage Table of Contents

Amendments, Riders and Notices (As Applicable)

Section 1: Definitions

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

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

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

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.

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

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

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

Dental Service or **Dental Procedures** - dental care or treatment provided by a Dental Provider to you while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

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 Services, perform dental surgery or administer anesthetics for dental surgery.

Dependent - (1.) the Subscriber's legal spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. or (2.) an unmarried Dependent child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, foster child, a legally adopted child or grandchild, a child or grandchild placed for adoption, or a child or grandchild for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse). The term child also includes a grandchild of either the Subscriber or the Subscriber's spouse. To be eligible for Coverage under the Policy, a Dependent must reside within the United States. The definition of Dependent is subject to the following conditions and limitations:

A. The term Dependent will not include any unmarried Dependent child 26 years of age or older, except as stated in *Section 3: Termination of Coverage, sub-section Coverage for a Disabled Dependent Child*.

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

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

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

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has established a Domestic Partnership. In no event will a person's legal spouse be considered a Domestic Partner.

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

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

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

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

B. For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Expenses are our contracted fee(s) for Covered Dental Services with a Network Dental Provider in the same geographic area.

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

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

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

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

Enrolling Group - the employer or other defined or otherwise legally constituted group (Association, Union, etc.) to whom the Policy is issued.

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

A. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or

B. Subject to review and approval by any institutional review board for the proposed use; or

C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

D. Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or

E. Pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.

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

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

Maximum Benefit - the maximum amount paid for Covered Dental Services during a calendar year for you under the Policy or any Policy, issued by us to the Enrolling Group, that replaces the Policy. The Maximum Benefit is stated in *Section 10: Covered Dental Services*.

Maximum Policy Benefit - the maximum amount paid for Network and Non-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 *Section 10: Covered Dental Services*.

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

Necessary - Dental Services and supplies which are determined by 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 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 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 - the collective group of Dental Providers, including specialist, who are subject to a participation agreement in effect with us, directly or through another entity, to provide Dental Services to you. The participation status of providers will change from time to time.

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

Non-Network - a Dental Provider who is not a participant in the Network.

Non-Network Benefits - Coverage available for Dental Services obtained from Non-Network Dental Providers.

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

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

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

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

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

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

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

Section 2: Eligibility and Effective Date of Coverage

Enrollment

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

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

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

If you fail to enroll yourself or a Dependent during the Initial Eligibility Period or during an Open Enrollment Period, you or your Dependent must wait 12 months before you or your Dependent is eligible to enroll for Dental benefits.

Effective Date of Coverage

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

If an Eligible Person enrolls during the Initial Eligibility Period, Coverage is effective on the date the Eligible Person joins the Enrolling Group.

Coverage for a Newly Eligible Person

Coverage for you and any of your Dependents will take effect on the date agreed to by the Enrolling Group and us. Coverage is effective only if we receive any required Premium and properly completed enrollment information within 31 calendar days of the date you first become eligible.

Coverage for a Newly Eligible Dependent

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

Change in Family Status

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

Special Enrollment Period

An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period or Open Enrollment Period may enroll for Coverage during a special enrollment period. A special enrollment period is available if the following conditions are met:

A. the Eligible Person and/or Dependent had existing health coverage under another plan at the time of the Initial Eligibility Period or Open Enrollment Period; and

B. Coverage under the prior plan was terminated as a result of loss of eligibility (including, without limitation, legal separation, divorce or death), termination of employer contributions, or in the case of COBRA continuation coverage, the coverage was exhausted.

A special enrollment period is not available if coverage under the prior plan was terminated for cause or as a result of failure to pay Premiums on a timely basis. Coverage under the Policy is effective only if we receive any required Premium and properly completed enrollment information within 6 months of the date coverage under the prior plan terminated. A special enrollment period is also available for an Eligible Person and for any Dependent whose status as a Dependent is affected by marriage, birth, placement for adoption or adoption, as required by federal law. In such cases you must submit the required Premium and properly completed enrollment information within 31 calendar days of the marriage, birth, placement for adoption or adoption.

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.

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; the required premiums for the child are not paid by the Premium due date; Dependent insurance is no longer available or you are no longer insured by the Policy.

Section 3: Termination of Coverage

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

We may, at any time, discontinue this benefit plan and/or all similar benefit plans for the reasons specified in the Policy. When your Coverage terminates, you may have continuation as described in *Section 8: Continuation of Coverage* or as provided under other applicable federal and/or state law.

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

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

B. The last day of the calendar month in which you cease to be eligible as a Subscriber, Enrolled Dependent or active member of the Policyholder.

C. The date we receive written notice from either the Subscriber or the Enrolling Group instructing us to terminate Coverage of the Subscriber or any Covered Person or the date requested in such notice, if later.

D. The date the Subscriber is retired or pensioned under the Enrolling Group's Plan, unless a specific Coverage classification is specified for retired or pensioned persons in the Enrolling Group's application and the Subscriber continues to meet any applicable eligibility requirements.

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

E. The date specified by us that all Coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided us with false material information, including, but not limited to, false, material information relating to residence, information relating to another person's eligibility for Coverage or status as a Dependent. We have the right to rescind Coverage back to the effective date subject to the Contestability of Coverage provision.

F. The date specified by us that all Coverage will terminate because the Subscriber permitted the use of his or her ID card by any unauthorized person or used another person's card.

G. The date specified by us that Coverage will terminate due to material violation of the terms of the Policy.

H. The date specified by us that your Coverage will terminate because you failed to pay a required Premium subject to the Grace Period provision.

I. The date specified by us that your Coverage will terminate because you have committed acts of physical or verbal abuse which pose a threat to our staff, a provider, or other Covered Persons.

Coverage for a Disabled Dependent Child

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

- Is not able to be self-supporting because of mental or physical incapacity or disability.
- Depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless Coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 calendar days of the date Coverage would otherwise 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 chosen by us 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 examinations at our expense. However, 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 calendar days of our request as described above, Coverage for that child will end.

Extended Coverage

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

Coverage for orthodontics will continue 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 date 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.

Benefits will be Covered for:

A. a Procedure in Progress or Dental Procedure that was recommended in writing and began, in connection with a specific dental disease of a Covered Person while the Policy was in effect, by the attending Dental Provider; or

B. an appliance, or modification to an appliance, for which the impression was taken prior to the termination of Coverage; or

C. a crown, bridge or gold restoration, for which the tooth was prepared prior to the termination of Coverage.

In the event of a grant of this temporary extension of Coverage, all other terms, conditions and limitations of this Policy will remain in effect, including, but not limited to: cost sharing and payment of Premium by the Subscriber.

Payment and Reimbursement Upon Termination

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

Section 4: Reimbursement

Reimbursement of Eligible Expenses

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

Filing Claims for Reimbursement of Eligible Expenses

You are responsible for submitting a request in writing for reimbursement to our office, on a form provided by or satisfactory to us, or in a manner satisfactory to us such as e-mail. Requests for reimbursement should be submitted within 90 calendar days after the date of service. Unless you are legally incapacitated, failure to provide this information to us within 365 calendar days from the above 90 day timeframe will cancel or reduce Coverage for the Dental Service. Coverage will not be cancelled or reduced if it is shown that it was not reasonably possible to provide this information within these time frames and it was provided as soon as was reasonably possible.

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

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

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

Proof of Loss. Written proof of loss should be given to us within 90 calendar days after the date of the loss. If it was not reasonably possible to give written proof in the time required, we will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 365 calendar days after the above 90 day timeframe.

Payment of Claims. Benefits are payable not more than 30 days after receipt of acceptable written proof of loss. When you obtain Covered Dental Services from Non-Network Dental Providers, you must file a claim with us and benefits will be paid directly to you. Benefits will be paid to you unless:

A. The Dental Provider notifies us that your signature is on file assigning benefits directly to that Dental Provider; or

B. You make a written request at the time the claim is submitted.

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

Section 5: Questions, Complaints and Appeals

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

What to Do if You Have a Question

Contact Customer Service at the telephone number shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact Customer Service at the telephone number shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

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

If the Customer Service representative cannot resolve the issue to your satisfaction 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.

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.
- "Compelling reason" means a showing that the potential delay in receipt of a health care service until after the member 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, or the member remaining seriously mentally ill with symptoms that cause the member to be in danger to self or others.
- "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.
- "Filing date" is the earlier of five days after the date the adverse decision grievance was mailed or the date of receipt.
- "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 a compelling reason 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 a condition establishing a compelling reason 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 following the verbal notification.

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

The adverse decision will be orally communicated to you, your representative or your healthcare provider within 1 day after a decision has been made and 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. If the adverse decision is a retrospective denial 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. 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.
- 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 for which a delay would result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ or the Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be in danger to self or others.

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.

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 of the adverse decision grievance. 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 explained in the Adverse Decision provision 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

THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES. 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.

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 Customer Care at 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. 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; TTY: 1-800-735-2258

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 a compelling reason exists.

Section 6: General Legal Provisions

Entire Policy

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

Contestability of Coverage

A statement made by any Covered Person under the Policy relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of 2 years during the Covered Person's lifetime.

No statement will be used to void or reduce coverage under this Policy unless:

- The statement is contained in a written instrument signed by the Enrolling Group or the Subscriber, and
- A copy of the statement is given to the Enrolling Group, Subscriber or beneficiary of the Subscriber.

Amendments and Alterations

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

Relationship Between Parties

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

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

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

Information and Records

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

By accepting Coverage 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 any and all records concerning dental care services which are necessary to implement and administer the terms of the Policy, for appropriate review or quality assessment, or as we are required to do 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.

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

If you request 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, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

ERISA

When the Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

Examination of Covered Persons

In the event of a question or dispute concerning Coverage for Dental Services, we may reasonably require that a Network Dental Provider acceptable to us examine you at our expense.

Clerical Error

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

Notice

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

Workers' Compensation Not Affected

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

Conformity with Statutes

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

Waiver/Estoppel

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

Headings

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

Unenforceable Provisions

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

Misstatement of Age

If the Company's records show an incorrect age for a Covered Person, the Company will pay benefits according to what would have been provided for the correct age.

If benefits were underpaid, the Company will pay the additional amount that is due.

If benefits were overpaid, the Company reserves the right to recover the amount of the overpaid benefit from the person who received the payment; or reduce future benefit payments by the amount of the overpayment.

The Company also reserves the right to make an equitable Premium adjustment based on the error.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the Coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties".

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
    - Providing any relevant information requested by us.
    - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or injuries.
    - Making court appearances.
    - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of dental benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of dental benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits we provided, plus reasonable costs of collection.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a sickness or injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Proceeds received by us will be reduced by a pro rate share of the court costs and legal fees incurred by the Covered Person applicable to the portion of the settlement returned to us. The Covered Person agrees to execute and deliver such documents (including a written confirmation of assignment, and

consents to release medical records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as we may reasonably request.

Refund of Overpayments

If we pay benefits for expenses incurred on account of you, that 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 by you 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, then you agree to help us get the refund when requested.

If you do not promptly refund the full amount, we may reduce the amount of any future benefits for you that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

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 4: Reimbursement. 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.

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.

When Coordination of Benefits Applies

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. 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. 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.

Definitions

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

A. 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; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: 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 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. 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 is a health care expense, including deductibles, coinsurance and copayments, 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 in accordance with a 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 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 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.

Order of Benefit Determination Rules

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.

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 as an employee, member, policyholder, subscriber or retiree longer 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.

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.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: Continuation of Coverage

If your Coverage ends under the Policy, you may be entitled 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 Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected 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 Enrolling 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 Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling 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.

Section 9: Procedures for Obtaining Benefits

Dental Services

You are eligible for Coverage for Dental Services listed in the *Schedule of Covered Dental Services* and *Section 10: Covered Dental Services* of this *Certificate* if such Dental Services are Necessary and are provided by or under the direction of a Dental Provider or other provider. All Coverage is subject to the terms, conditions, exclusions and limitations of the Policy.

Network and Non-Network Benefits

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

Network Benefits

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

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

Enrolling for Coverage under the Policy does not guarantee Dental 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 Services. You must show your ID card every time you request Dental Services.

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

Coverage for Dental Services is subject to payment of the Premium required for Coverage under the Policy, satisfaction of any applicable deductible, appropriate Waiting Period, payment of the Copayment specified for any service and payment of the percentage of Eligible Expenses shown in the *Schedule of Covered Dental Services* and *Section 10: Covered Dental Services* and generally require you to pay less to the Dental Provider than Non-Network Benefits. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event will you be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

Non-Network Benefits

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

Before you are eligible for Coverage of Dental Services obtained from Non-Network Dental Providers, you must meet the requirements for payment of the applicable deductible and appropriate Waiting Period specified in the *Schedule of Covered Dental Services* and *Section 10: Covered Dental Services*. Generally you are required to pay more than Network Benefits. Non-Network Dental Providers may

request that you pay all charges when services are rendered. You must file a claim with us for reimbursement of Eligible Expenses.

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

The difference between the coinsurance percentage applicable to Non-Network Dental Providers and the coinsurance percentage applicable to Network Dental Providers will not be greater than 20 percent.

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 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 Non-Network Dental Providers had been used. The Copayment level (the percentage of Covered expenses for which you are responsible) 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.

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

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 the website listed on your ID card. You can also call customer service to determine which Dental Providers participate in the Network. The telephone number for customer services is on the ID card.

Network Dental Providers are responsible for submitting a request for payment directly to us, however, you are responsible for any Copayment at the time of service. If a Network Dental Provider bills you, customer services should be called. You do not need to submit claims for Network Dental Provider services or supplies.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify 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 Covered 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.

Section 10: Covered Dental Services

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

A. Necessary;

B. Provided by or under the direction of a Dental Provider; and

C. Not excluded as described in *Section 11: General Exclusions*.

Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a benefit based on the least costly procedure.

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

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

Network Benefits:

When Network Copayments are charged as a percentage of Eligible Expenses, the amount you pay for Dental Services from Network Dental Providers 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 Services and will not be payable by us.

Non-Network Benefits:

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

Maximum Benefit

Maximum Benefit is $5,000 per Covered Person for Network Benefits and $5,000 per Covered Person for Non-Network Benefits per calendar year.

Maximum Benefit for Network Benefits applies to any combination of the following Covered Dental Services: MINOR RESTORATIVE SERVICES, ENDODONTICS, PERIODONTICS, ORAL SURGERY, ADJUNCTIVE SERVICES, MAJOR RESTORATIVE SERVICES, FIXED PROSTHETICS, REMOVABLE PROSTHETICS, IMPLANT PROCEDURES.

Maximum Benefit for Non-Network Benefits applies to any combination of the following Covered Dental Services: MINOR RESTORATIVE SERVICES, ENDODONTICS, PERIODONTICS, ORAL SURGERY, ADJUNCTIVE SERVICES, MAJOR RESTORATIVE SERVICES, FIXED PROSTHETICS, REMOVABLE PROSTHETICS, IMPLANT PROCEDURES.

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

Consumer Max Multiplier

If a Covered Person has claims for Covered Dental 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 Eligible Expense incurred during the preceding calendar year; and

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

In each succeeding calendar year in which the reimbursement for Eligible Expenses 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, Eligible Expenses 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 Eligible Expenses incurred during the preceding calendar year are submitted. In this instance, there will be no carry over amount for the calendar year, any accumulated carry over amounts from previous calendar year will be forfeited.

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 Eligible Expenses incurred during the calendar year. In order to properly calculate the carry over amount, claims should be submitted timely in accordance with the proof of loss provision found within *Section 4: Reimbursement*.

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

Maximum Policy Benefit is $1,500 per Covered Person for Network Benefits and $1,500 per Covered Person for Non-Network Benefits.

Maximum Policy Benefit for Network Benefits applies to: ORTHODONTICS.

Maximum Policy Benefit for Non-Network Benefits applies to: ORTHODONTICS.

Prenatal Dental Care

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

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).

Section 11: General Exclusions

Exclusions

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

A. Dental Services that are not Necessary.

B. Hospitalization or other facility charges.

C. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance such as labial veneers.)

D. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.

E. Any Dental Procedure not directly associated with dental disease.

F. Any Dental Procedure not performed in a dental setting.

G. Procedures that are considered to be Experimental, Investigational or Unproven. 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.

H. Any implant procedures performed which are not listed as Covered implant procedures in the *Schedule of Covered Dental Services*.

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

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

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

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

M. Replacement of complete dentures, 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.

N. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

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

P. For the first 12 months of coverage, expenses for Dental Procedures begun 12 months prior to you becoming covered under the Policy.

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

R. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

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

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

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

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

W. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates, subject to the Extended Coverage provision.

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

Y. 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.

Z. In the event that a Non-Network Dental Provider routinely waives Copayments and/or the applicable deductible for a particular Dental Service, the Dental Service for which the Copayments and/or applicable deductible are waived is reduced by the amount waived by the Non-Network Dental Provider.

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

BB. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

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

DD. Any Dental Services or Procedures that the appropriate regulatory board determines were provided as a result of a prohibited referral.

SCHEDULE OF COVERED DENTAL SERVICES

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
DIAGNOSTIC SERVICES		
Bacteriologic Cultures	0%	0%
Viral Cultures	0%	0%
Intraoral Bitewing Radiographs 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 36 months.	0%	0%
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 cannot be billed in conjunction with a complete series.	0%	0%
Intraoral Periapical Radiographs Image Limited to 8 images per calendar	0%	0%

BENEFIT DESCRIPTION & LIMITATION	**NETWORK COPAYMENT** is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied.	**NON-NETWORK COPAYMENT** is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
year.		
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 service.	0%	0%
Comprehensive Periodontal Evaluation - new or established patient	0%	0%

BENEFIT DESCRIPTION & LIMITATION	**NETWORK COPAYMENT** is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied.	**NON-NETWORK COPAYMENT** is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Limited to 2 times per consecutive 12 months.		
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%
Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures Limited to 1 time per consecutive 12 months.	0%	0%
PREVENTIVE SERVICES		
Dental Prophylaxis Limited to 2 times per consecutive 12 months.	0%	0%
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	0%	0%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.		
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%
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%
Composite Resin Restorations - Posterior Multiple restorations on one surface will be treated as a single filling.	10%	10%
Gold Foil Restorations Multiple restorations on one	10%	10%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
surface will be treated as a single filling.		
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 retreatment codes on tooth treated for the first 12 months.	10%	10%
Retreatment of Previous Root Canal Therapy Dentist who performed the original root canal should not be reimbursed for the treatment 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	10%	10%

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secondary tooth per lifetime.		
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration) Limited to 1 time per tooth per lifetime. Covered for anterior or posterior teeth only.	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 Permanent Tooth with a Necrotic Pulp) does not include Final Restoration Limited to 1 time per tooth per lifetime.	10%	10%
PERIODONTICS		
Crown Lengthening Limited to 1 per quadrant or site per consecutive 36 months.	10%	10%
Gingivectomy/Gingivoplasty Limited to 1 per quadrant or site per consecutive 36 months.	10%	10%

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Gingival Flap Procedure Limited to 1 per quadrant or site per consecutive 36 months.	10%	10%
Osseous Graft Limited to 1 per quadrant or site per consecutive 36 months.	10%	10%
Osseous Surgery Limited to 1 per quadrant or site per consecutive 36 months.	10%	10%
Guided Tissue Regeneration Limited to 1 per quadrant or site per consecutive 36 months.	10%	10%
Soft Tissue Surgery Limited to 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%
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	10%	10%

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based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.		
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 per lifetime for refractory pockets or in conjunction with Periodontal Scaling and Root Planing.	10%	10%
ORAL SURGERY		
Alveoloplasty	10%	10%
Biopsy Limited to 1 biopsy per site per visit.	10%	10%
Brush 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%

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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 time per tooth per lifetime.	10%	10%
Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth Limited to 1 time per tooth per lifetime.	10%	10%
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	10%	10%

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lifetime.		
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 Transplantation Services Limited to 1 per site per lifetime.	10%	10%
Oroantral Fistula Closure Limited to 1 per site per visit.	10%	10%
ADJUNCTIVE SERVICES		
Analgesia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically	10%	10%

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Necessary. Covered for patients over age of 6 if it is clinically Necessary.		
Desensitizing Medicament	10%	10%
General Anesthesia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	10%	10%
Local Anesthesia Not Covered in conjunction with operative or surgical procedure.	10%	10%
Intravenous Sedation and Analgesia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	10%	10%
Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report	10%	10%
Occlusal Adjustment	10%	10%
Occlusal Guards	10%	10%

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Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.		
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%
Palliative Treatment Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.	10%	10%
Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.) Not Covered if done with exams or professional visit.	10%	10%
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	40%	40%

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as a crown on same tooth.		
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 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 - 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%
Inlays/Onlays - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore	40%	40%

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the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.		
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 tooth 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 tooth per consecutive 60 months.	40%	40%
Post and Cores Covered only for teeth that have had root canal therapy.	40%	40%
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%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
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%
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%
REMOVABLE PROSTHETICS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Full Dentures Limited to 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	40%	40%

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months.		
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%
IMPLANT PROCEDURES 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 Limited to 1 time per tooth per consecutive 60 months.	50%	50%
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 repairs or adjustments performed more than 12 months after initial insertion. Limited to 1	50%	50%

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per consecutive 6 months.		
Abutment Supported Crown (titanium) or Retainer Crown for FPD - titanium Limited to 1 time per tooth per 60 consecutive months.	50%	50%
Repair Implant Abutment, by report Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to 1 per consecutive 6 months.	50%	50%
Implant Removal, by report Limited to 1 time per tooth per 60 consecutive months.	50%	50%
ORTHODONTICS Orthodontic services are subject to the applicable Waiting Period, satisfaction of any Deductible and any orthodontic Deductible, and payment of any applicable Copayments.		
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 COPAYMENT is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Cephalometric Radiographic Image Limited to 1 per consecutive 12 months. Can only be billed for orthodontics.	50%	50%

Identification Card Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, Policy and *Certificate* references to Identification (ID) Card are modified as shown below.

The following language replaces the Identification Card provision in the ***Introduction to Your Certificate***:

Identification (ID) Card

You are not required to show an Identification (ID) Card to receive Dental Services. You may be required to provide identification information to your Dental Provider to verify your eligibility for benefits (name or date of birth).

You may obtain an ID Card by going to our website, www.myuhc.com, and printing one for yourself.

For any references in the *Certificate* to information available on Your ID Card please contact our Customer Service Department at the telephone number shown on your ID card.

The following language is removed from ***Section 9: Procedures for Obtaining Benefits*****, Network Benefits** provision as we no longer require the Covered Person to show their ID to receive Dental Services:

You must show your ID card every time you request Dental Services.

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

The following language is added to ***Section 9: Procedures for Obtaining Benefits*****, Network Benefits:**

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

The following language is removed from ***Section 9: Procedures for Obtaining Benefits*****, Network Dental Providers** provisions as we no longer require the Covered Person to show their ID to receive Dental Services:

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

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

UNITEDHEALTHCARE INSURANCE COMPANY

William J Golden, President

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 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCION: 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 الأتصال 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 વિના 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 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, 1-800-537-7697 (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, 2019

We[2] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

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

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

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

How We Use or Disclose Information

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

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

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

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

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

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

- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.

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

- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

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

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

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

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

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

- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.

- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.

- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

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

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

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

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

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

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

What Are Your Rights

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

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**

- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

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

- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.

- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

- **You have the right to a paper copy of this notice**. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your dental plan website, such as www.myuhc.com.

Exercising Your Rights

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

  UnitedHealthcare

  Dental HIPAA - Privacy Unit

  PO Box 30978

  Salt Lake City, UT 84130

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

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

[2]*This Dental Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; National Pacific Dental, Inc.; Unimerica Insurance Company; UnitedHealthcare Insurance Company and UnitedHealthcare Insurance Company of New York. This list of dental plans is complete as of the effective date of this notice. For a current list of dental plans subject to this notice go to www.uhc.com/privacy/entities-fn-v5-en or call 1-800-445-9090.*

FINANCIAL INFORMATION PRIVACY NOTICE

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

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2019

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

Disclosure of Information

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

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

Confidentiality and Security

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

Questions about this Notice

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

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

plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of dental plans is complete as of the effective date of this notice. For a current list of dental plans subject to this notice go to www.uhc.com/privacy/entities-fn-v5-en or call 1-800-445-9090.

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 $110 a day 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
860-702-5000

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.