UnitedHealthcare Solstice Dental

UnitedHealthcare Insurance Company

Certificate of Coverage

For

DG3 NORTH AMERICA INC

Dental Plan Number: SNJ01

Enrolling Group Number: 918619

Effective Date: January 1, 2022

Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

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

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

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

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

Can This Certificate Change?

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

Other Information You Should Have

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

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

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

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

Introduction to Your Certificate

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

What Are Defined Terms?

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

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

How Do You Use This Document?

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

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

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

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

How Do You Contact Us?

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

Your Responsibilities

Enrollment and Required Contributions

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

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

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

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

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

Decide What Services You Should Receive

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

Choose Your Dental Provider

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

Pay Your Share

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

Pay the Cost of Excluded Services

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

File Claims with Complete and Accurate Information

When you receive Covered Dental Care Services from an out-of-Network provider, you have the right to make an assignment of Benefits, whereby your provider may request payment from us. You may also request payment on our own behalf at your option. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Our Responsibilities

Determine Benefits

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

We have the final authority to do the following:

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

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

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

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

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

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

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

Certificate of Coverage Table of Contents

Section 1: Covered Dental Care Services

When Are Benefits Available for Covered Dental Care Services?

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

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

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

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

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

One example is:

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

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

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

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

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

1. Classes of Dental Benefits

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

Class I - Dental Benefits

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

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

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

Class II - Dental Benefits

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

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

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

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

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

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

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

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

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

Class III - Dental Benefits

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

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

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

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

Class IV - Dental Benefits

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

2. Virtual Visits

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

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

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

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

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

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

3. Prenatal Dental Care

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

Credit for Prior Coverage

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

Pre-Treatment Estimate

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

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

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

Section 2: Exclusions and Limitations

We Do Not Pay Benefits for Exclusions

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

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

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

Where Are Benefit Limitations Shown?

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

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

Exclusions

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

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

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

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

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

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

13. Replacement of complete dentures, fixed and removable partial dentures or crowns, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is due to patient non-compliance, the patient is liable for the cost of replacement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 3: When Coverage Begins

How Do You Enroll?

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

Who Is Eligible for Coverage?

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

Eligible Person

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

Eligible Persons must live within the United States.

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

Dependent

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

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

The term spouse also includes Civil Union Partners as defined by, and in accordance with New Jersey law and the valid laws of another jurisdiction under which a civil union relationship was created.

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

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

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

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

Open Enrollment Period

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

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

New Eligible Persons

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

Adding New Dependents

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

- Birth. Coverage for a newborn child begins at the moment of birth and continues for 60 days as if the child were enrolled, provided we receive any additional Premium for those 60 days that is required.
- Legal adoption.
- Placement for adoption.
- Marriage or civil union.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

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

Special Enrollment Period

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

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

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

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

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

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health*

Insurance Program (CHIP). Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.

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

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

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

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

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

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

Fraud or Intentional Misrepresentation of a Material Fact

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

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

Coverage for a Disabled Dependent Child

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

- The Enrolled Dependent child is not able to support him/herself because of intellectual disability or physical handicap or disability.
- The Enrolled Dependent child depends mainly on the Subscriber for support.

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

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

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

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

Extended Coverage for Total Disability

A temporary extension of coverage, only for treatment of the condition causing a Total Disability, will be granted to a Covered Person who is Totally Disabled on the date the person's coverage is terminated due to termination of the entire Policy. Benefits will be covered until (a) the Total Disability ends or (b) 90 days from the date the Policy terminated, whichever is less. Such benefits are subject to the terms and conditions of the Policy.

Extended Coverage

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

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

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

Continuation of Coverage

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

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

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

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

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

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

Section 5: How to File a Claim

How Are Covered Dental Care Services from Network Providers Paid?

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

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

When you receive Covered Dental Care Services from an out-of-Network provider, if you make an assignment of Benefits, the out-of-Network provider is responsible requesting payment from us. The out-of-Network provider must file the claim in a format that contains all of the information we require, as described below. At your option, you may also submit the claim to us directly.

Your out-of-Network provider should submit a request for payment of Benefits within 90 days after the date of service. If you have assigned benefits to the out-of-Network provider, as described below, the out-of-Network provider should submit a request for payment of Benefits within 180 days after the date of service. IF this information is not provided to us within one year of the date of service, Benefits for that dental care service will be denied or reduced, subject to the appeal provisions in *Section 6, Questions, Complaints and Appeals*. This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider(s) including a complete dental chart showing extractions, fillings or other Dental Care Services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports, as applicable.
- Casts, molds or study models, as applicable.
- An itemized bill which includes the CDT codes or a description of each charge.
- The date the dental disease began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other dental plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

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

Payment of Benefits

We will pay Benefits within the time frames shown below after we receive a request for payment that includes all required information.

- 30 days after we receive a request submitted by electronic means.
- 40 days after we receive a request submitted by other than electronic means.

Requests for payment that include all required information which are not paid within these time frames will include an overdue payment of simple interest at the rate of 12% per annum.

You may not assign your Benefits under the Policy or any cause of action related to your Benefits under the Policy to an out-of-Network Dental Provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to the Subscriber for reimbursement to an out-of-Network provider. We may, as we determine, pay an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network Dental Provider, we have the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to an out-of-Network Dental Provider with our consent, and the out-of-Network Dental Provider submits a claim for payment, you and the out-of-Network Dental Provider represent and warrant the following:

- The Covered Dental Care Services were actually provided.
- The Covered Dental Care Services were dentally appropriate.

Payment of Benefits under the Policy shall be in cash or cash equivalents, or in a form of other consideration that we determine to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes us, or to other plans for which we make payments where we have taken an assignment of the other plans' recovery rights for value.

Section 6: Questions, Complaints and Appeals

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

What if You Have a Question?

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

What if You Have a Complaint?

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

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

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

How Do You Appeal a Claim Decision?

Post-service Claims

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

Pre-service Requests for Benefits

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

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 care 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 first 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 expertise 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 to 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 defined 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 defined 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 urgent action if a delay in treatment could 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.

Section 7: General Legal Provisions

What Is Your Relationship with Us?

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

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

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

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

What Is Our Relationship with Providers and Groups?

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

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

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

The Group is solely responsible for all of the following:

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

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

What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

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

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

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

Notice

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

Statements by Group or Subscriber

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

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Dental Provider. Contact us at www.myuhc.com or contact us at 1-800-445-9090 if you have any questions.

From time to time we may offer or provide certain persons who apply for coverage with us or become insureds/enrollees with UnitedHealthcare Insurance Company with dental or oral health goods and/or services otherwise not covered under the Policy. In addition, we may arrange for third party dental or oral health providers, to provide discounted goods and services to those persons who apply for coverage with us or who become insureds/enrollees of UnitedHealthcare Insurance Company. While we have arranged these goods or services and/or third party provider discounts, the third party service providers are liable to the applicants/insureds/enrollees for the provision of such goods and/or services. We are not responsible for the provision of such goods and/or services nor are we liable for the failure of the provision of the same. Further, we are not liable to the applicants/insureds/enrollees for the negligent provision of such goods and/or services by third party service providers.

Who Interprets Benefits and Other Provisions under the Policy?

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

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

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

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

Who Provides Administrative Services?

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

Amendments to the Policy

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

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

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

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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

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

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

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

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

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

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

Do We Require Examination of Covered Persons?

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

Is Workers' Compensation Affected?

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

Covered Persons - Hold Harmless

The Network provider agrees that with respect to Covered Dental Care Services in no event, including, but not limited to: (1) non-payment by an organization with which we have contracted; (2) insolvency of us or any organization with which we have contracted; or (3) breach of any agreement between the Network provider and us; shall the Network Dental Care Providers, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Persons. This provision shall not prohibit collection of any Copayments, Coinsurance or Deductibles in accordance with the terms of the Network Dental Care Provider's agreement with us.

When Do We Receive Refunds of Overpayments?

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

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

- All or some of the payment was made in error.

Except in cases of fraudulent claims, we will make a written request for the reimbursement no later than 18 months after the date the first payment of the claim was made. The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

In seeking reimbursement for the overpayment from the Dental Provider, we will not collect or attempt to collect:

- the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the Dental Provider;
- the funds for the reimbursement if the Dental Provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the Dental Provider and until the Dental Provider's rights to appeal are exhausted; or
- a monetary penalty against the reimbursement request, including but not limited to, an interest charge or a late fee.

We may collect the funds for the reimbursement request by assessing them against payment of any future claims submitted by the Dental Provider after the 45th calendar day following the submission of the reimbursement request to the Dental Provider or after the Dental Provider's rights to appeal have been exhausted if we submit an explanation in writing to the provider in sufficient detail so that the provider can reconcile each Covered Person's bill.

If we determine that the overpayment to the Dental Provider is a result of fraud committed by the Dental Provider and we have conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, we may collect an overpayment by assessing it against payment of any future claim submitted by the Dental Provider.

Is There a Limitation of Action?

No legal action may be brought against us prior to the expiration of 60 days after proof of loss has been filed. Additionally, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

What Is the Entire Policy?

The Policy, this *Certificate*, the *Schedule of Covered Dental Care Services*, the Group's *Application* which is attached to the Policy, and any Riders and/or Amendments, make up the entire Policy that is issued to the Group. No such statement shall void or reduce Coverage under the Policy or be used in defense of a legal action unless it is contained in a written application signed by the Group or by a Subscriber, as applicable.

Section 8: Defined Terms

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

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

Civil Union Partners - an individual who is a partner in a civil union. A civil union is defined as, the legally recognized union of two eligible individuals, of the same sex, established pursuant to (or otherwise compliant with) New Jersey law. A civil union also includes relationships entered into under the laws of other jurisdictions provided such relationships provide all of the rights and benefits of marriage.

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

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

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

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

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

- The Co-payment.
- The Allowed Amount.

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

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

- Necessary.
- Treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.
- Described as a Covered Dental Care Service in this *Certificate* under *Section 1: Covered Dental Care Services* and in the *Schedule of Covered Dental Care Services*.
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

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

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

Dependent - the Subscriber's legal spouse, Civil Union Partner or a child of the Subscriber or the Subscriber's spouse, Civil Union Partner. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section*

3: When Coverage Begins, the Group determines who is eligible to enroll and who qualifies as a Dependent. To be eligible for Coverage under the Policy, a Dependent must reside within the United States. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- The term child also includes a grandchild of either the Subscriber or the Subscriber's spouse.
- A child for whom dental care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

The following conditions apply:

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

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

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

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

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

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

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

As of February 19, 2007 only those Domestic Partnerships registered prior to February 19, 2007 may continue to renew/purchase coverage.

Same sex Domestic Partners who entered into a Domestic Partnership prior to February 19, 2007 have the right to enter into a Civil Union pursuant to New Jersey law. Entry into a Civil Union will terminate the Domestic Partnership.

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

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

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

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

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
- Pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.

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

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

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

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

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

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

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

A. needed to meet your basic dental needs; and

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

C. consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us; and

D. consistent with the diagnosis of the condition; and

E. required for reasons other than the convenience of you or your Dental Provider; and

F. demonstrated through prevailing peer-reviewed dental literature to be either:

1. safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; or

2. safe with promising efficacy:

a. for treating a life threatening dental disease or condition; and

b. in a clinically controlled research setting; and

c. using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

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

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

A provider may enter into an agreement to provide only certain Covered Dental Care Services, but not all Covered Dental Care Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Dental Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Dental Care Services and products. The participation status of providers will change from time to time. Covered Dental Services provided by an out-of-Network Dental Provider are considered Network Benefits when such services are for Emergency care.

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

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

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

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that

we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

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

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

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

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

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

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

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

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

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Schedule of Covered Dental Care Services

How Do You Access Benefits?

This Schedule of Covered Dental Care Services: (1) describe the Covered Dental Care Services and any applicable limitations to those services; (2) outline the Co-payments that you are required to pay for each Covered Dental Care Service.

Network Dental Providers

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

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

Directory of Network Dental Providers

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

Network and out-of-Network Benefits

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

Network Benefits

Dental Care Services must be provided by a Network Dental Provider in order to be considered Network Benefits. When Covered Dental Care Services are received from a Network Dental Provider, Allowed Amounts are our contracted fee(s) with that provider.

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

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

Covered Dental Care Services must be provided by or directed by a Network Dental Provider.

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

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

Coverage for Dental Care Services is subject to payment of the Premium required for Coverage under the Policy and payment of the Co-payment specified for any service. Network Benefits are determined based on the contracted fee for each Covered Dental Care Service. In no event will you be required to pay a Network Dental Provider an amount for a Covered Dental Care Service in excess of the contracted fee.

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

Covered Dental Care Services are subject to payment of any Co-payments as stated below.

Out-of-Network Benefits

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

Generally you are required to pay more than Network Benefits. Out-of-Network Dental Providers may request that you pay all charges when services are rendered. You must file a claim with us for reimbursement of Allowed Amounts.

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

The following definitions apply for this plan.

General Dental Provider - a Dental Provider who provides general Dental Care Services.

Specialty Dental Provider- a Dental Provider who provides specialized Dental Care Services.

Specialty Referral - A referral for Dental Care Services for endodontics, oral surgery, pediatric dentistry, orthodontics and periodontics.

Specialty Services

1. This Covered Person's Schedule of Covered Dental Care Services applies when listed Dental Care Services are performed by a Network General Dental Provider, unless otherwise authorized.
2. Procedures not listed on the Schedule of Covered Dental Care Services that are performed by a Network General Dental Provider will be charged at the Network General Dental Provider's Usual and Customary fee less 25%.
3. The Network General Dental Provider you select may not perform all procedures listed. The Co-payments shown apply to Network General Dental Providers.
4. Should the Dental Care Services of a specialist (Oral Surgeon, Endodontist, Periodontist, or Pediatric Dental Provider) be Necessary, you may receive this care in either of two ways: (1) You may go directly to a Network Specialty Dental Provider with no referral and receive a 25% reduction off the Specialty Dental Provider's Usual and Customary fee; or (2) You may obtain prior written authorization from us and receive specialty treatment by an approved Network Specialty Dental Provider at the listed Co-payments.
5. Should the Dental Care Services of an Orthodontist be Necessary, you may receive care in either of two ways: (1) You may go directly to a Network Specialty Dental Provider with no referral and receive a 25% reduction off the Specialty Dental Provider's Usual and Customary fee; or (2) You may contact Customer Service to locate your nearest Network Orthodontist who will perform Covered Dental Care Services at the listed Covered Person's Co-payment.

6. Covered Person's seeking implant treatment should refer to their Network implantologist, a select Network of Dental Providers. Not all Dental Providers perform the implant procedures at the Co-payment listed on the Schedule of Covered Dental Care Services.

ADA	DESCRIPTION	MEMBER PAYS
	DIAGNOSTIC SERVICES	
D0120*	PERIODIC ORAL EVALUATION EST PT	$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	$0
D0145*	ORAL EVAL PT<3 AND COUNSEL	$0
D0150*	COMP ORAL EVALUATION - NEW/EST PT	$0
D0160*	DTL & EXT ORAL EVAL - PROBLEM FOCUS REPORT	$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	$0
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE VISIT	$0
D0180*	COMP PERIODONTAL EVAL - NEW/EST PT	$0
D0210*	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC IMAGES	$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$4
D0230	INTRAORL PERIAPICAL EACH ADD RADIOGRAPHIC IMAGE	$2
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	$0
D0251*	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	$0
D0270*	BITEWING - SINGLE RADIOGRAPHIC IMAGE	$0
D0272*	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$0
D0273*	BITEWINGS - THREE RADIOGRAPHIC IMAGES	$0
D0274*	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$0
D0277*	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$30
D0310	RADIOGRAPHS -SIALOGRAPHY	$150
D0320	TMJ - INCLUDING INJECTION	$250
D0321	OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES	$150
D0322	TOMOGRAPHIC SURVEY	$150
D0330*	PANORAMIC RADIOGRAPHIC IMAGE	$50
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	$150
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY	$20
D0364*	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$140
D0365*	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$130
D0366*	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$130
D0367*	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS	$175
D0368*	CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$130
D0369*	MAXILLOFACIAL MRI CAPTURE AND INTERPRETATION	$180
D0370*	MAXILLOFACIAL ULTRASOUND CAPTURE AND INTERPRETATION	$160
D0371*	SIALOENDOSCOPY AND CAPTURE AND	$160
D0380*	CONE BEAM CT IMAGE CAPTURE WITH LIMITED	$140
D0381*	FIELD OF VIEW-LESS THAN ONE WHOLE JAW CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$130
D0382*	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$130
D0383*	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF BOTH JAWS	$175
D0384*	CONE BEAM CT IMAGE CAPTURE FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$130
D0385*	MAXILLOFACIAL MRI IMAGE CAPTURE	$160
D0386*	MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE	$160
D0393*	SIMULATION USING 3D IMAGES	$0
D0394*	DIGITAL SUBTRACTION OF IMAGES	$0
D0395*	FUSION OF TWO OR MORE 3D IMAGES	$0
D0415	COLLECT MICROORGANISMS CULT & SENS	$0
D0425	CARIES SUSCEPTIBILITY TESTS	$0
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	$65
D0460	PULP VITALITY TESTS	$0
D0470	DIAGNOSTIC CASTS	$0
D0472	ACCESS TISSUE, GROSS EXAM - PREP & REPORT	$0
D0473	ACCESS TISSUE, GROSS & MICROSCOPIC - PREP/REPORT	$0
D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG MARG PREP/REPORT	$0
D0480	PROCESSING AND INTERP OF EXFOLIATIVE CYTOLOGICAL SMEARS, INCL PREP AND TRANS OF WRITTEN REPORT	$0
D0486	ACCESSION OF TRANSEPITHELIAL CYTOLOGIC SAMPLE, MICCROSCOPIS EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	$0
D0502	OTHER ORAL PATHOLOGY PROCEDURES	$0
D0600	NON-IONIZING DIAGNOSTIC PROCEDURE CAPABLE OF QUANTIFYING, MONITORING, AND RECORDING CHANGES IN STRUCTURE OF ENAMEL, DENTIN AND CEMENTUM	$0
D0601	CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	$0
D0602	CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	$0
D0603	CARIES RISK ASSESSMENT AND DOCUMENTATION, HIGH	$0
D0701	PANORAMIC RADIOGRAPHIC IMAGE - IMAGE CAPTURE ONLY	$50
D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE - IMAGE CAPTURE ONLY	$150
D0703	2-D ORAL/FACIAL PHOTOGRAPHIC IMAGE INTRA-ORALLY OR EXTRA-ORALLY-IMAGE CAPTURE ONLY	$20
D0705	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	$0
D0706	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	$0
D0707	INTRAORAL-PERIAPICAL RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	$2
D0708	INTRAORAL-BITEWING RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	$0
D0709	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES-IMAGE CAPTURE ONLY	$0
	PREVENTIVE SERVICES	
D1110*	PROPHYLAXIS - ADULT	$0
D1110*	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN 6 MONTHS	$35
D1120*	PROPHYLAXIS - CHILD	$0
D1120*	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6 MONTHS	$22
D1206*	TOPICALFLUORIDE VARNISH	$20

ADA	DESCRIPTION	MEMBER PAYS
PREVENTIVE SERVICES		
D1208*	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	$0
D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	$0
D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	$0
D1330	ORAL HYGIENE INSTRUCTIONS	$0
D1351*	SEALANT - PER TOOTH	$0
D1352*	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	$0
D1353	SEALANT REPAIR - PER TOOTH	$0
D1354	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION	$20
D1355	CARIES PREVENTIVE MEDICAMENT APPLICATION - PER TOOTH	$20
D1510*	SPACE MAINTAINER - FIXED, UNILATERAL/QUAD	$0
D1516*	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	$0
D1517*	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	$0
D1520*	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	$0
D1526*	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	$0
D1527*	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	$0
D1551	RECEM/REBOND BILATERAL SPACE MAINTAINER - MAXIL	$20
D1552	RECEM/REBOND BILATERAL SPACE MAINTAINER - MANDIB	$20
D1553	RECEM/REBOND UNILATERAL SPACE MAINTAINER/QUAD	$20
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER/QUAD	$20
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	$20
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIB	$20
D1575	DISTAL SHOE SPACE MAINTAINER - FIXED, UNILATERAL/QUAD	$0
RESTORATIVE SERVICES		
D2140	AMALGAM - ONE SURFACE PRIMARY/PERMANENT	$12
D2150	AMALGAM - TWO SURFACES PRIMARY/PERMANENT	$20
D2160	AMALGAM - 3 SURFACES PRIMARY/PERMAMENT	$23
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	$25
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	$35
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	$45
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	$60
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	$85
D2390	RESIN COMPOSITE CROWN ANTERIOR	$125
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	$70
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	$80
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	$95
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	$120
D2410	GOLD FOIL - ONE SURFACE	$75
D2420	GOLD FOIL - TWO SURFACES	$95
D2430	GOLD FOIL - THREE SURFACES	$125
D2510	INLAY - METALLIC - ONE SURFACE	$270
D2520	INLAY - METALLIC - TWO SURFACES	$270
D2530	INLAY - METALLIC - 3/MORE SURFACES	$270
D2542	ONLAY - METALLIC - TWO SURFACES	$325
D2543	ONLAY - METALLIC THREE SURFACES	$340
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	$350

ADA	DESCRIPTION	MEMBER PAYS
D2610*	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	$275*
D2620*	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	$300*
D2630*	INLAY - PORCELAIN/CERAMIC - 3/MORE SURFACES	$325*
D2642*	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	$360*
D2643*	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	$390*
D2644*	ONLAY - PORCELAIN/CERAMIC - 4/MORE SURFACES	$400*
D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	$225
D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	$240
D2652	INLAY - RESIN BASED COMPOSITE - 3/>SURFACES	$270
D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	$245
D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	$265
D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	$285
D2710*	CROWN - RESIN - BASED COMPOSITE INDIRECT	$195
D2712*	CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT	$195
D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	$290*
D2721*	CROWN - RESIN W/PREDOM BASE METAL	$290*
D2722*	CROWN - RESIN WITH NOBLE METAL	$290*
D2740*	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$290*
D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	$290*
D2751*	CROWN - PORCELAIN FUSED PREDOM BASE METAL	$290*
D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	$290*
D2753	CROWN PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$290
D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	$290*
D2781*	CROWN - 3/4 CAST PREDOM BASE METAL	$290*
D2782*	CROWN - 3/4 CAST NOBLE METAL	$290*
D2783*	CROWN - 3/4 PORCELAIN/CERAMIC	$290*
D2790*	CROWN - FULL CAST HIGH NOBLE METAL	$290*
D2791*	CROWN - FULL CAST PREDOM BASE METAL	$290*
D2792*	CROWN - FULL CAST NOBLE METAL	$290*
D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	$290*
D2799*	PROVISIONAL CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$125
D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	$15
D2915	RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFABRICATED POST & CORE	$20
D2920	RECEMENT OR RE-BOND CROWN	$25
D2921	REATTACHMENT OF TOOTH FRAGMENT	$25
D2928	PREFABRICATED PORCELAIN/CERAMIC CROWN - PERMANENT TOOTH	$34
D2929*	PREFABRICATED PORCELAIN CROWN- PRIMARY	$34*
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY	$50
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT	$75
D2932	PREFABRICATED RESIN CROWN	$95
D2933	PREFABRICATED STAINLESS STEEL CROWN RESIN WINDOW	$145
D2940	SEDATIVE FILLING	$20
D2941	INTERIM THERAPEUTIC RESTORATION - PRIMARY DENTITION	$20
D2949	RESTORATIVE FOUNDATION FOR AN INDIRECT RESTORATION	$20
D2950	CORE BUILDUP INCLUDING ANY PINS	$75
D2951	PIN RETENTION - PER TOOTH ADDITION REST	$20
D2952	POST & CORE ADD CROWN INDIRECT FAB	$95
D2953	EACH ADD INDIRECT FABRICATED POST SAME TOOTH	$95

ADA	DESCRIPTION	MEMBER PAYS
RESTORATIVE SERVICES		
D2954	PREFABRICATED POST & CORE ADDITION CROWN	$90
D2955	POST REMOVAL	$35
D2957	EACH ADD PREFABR POST - SAME TOOTH	$30
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	$200
D2961*	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	$255*
D2962*	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	$390*
D2971	ADD PROCEDURE NEW CROWN XST PART DENTURE	$45
D2975	COPING	$95
D2980	CROWN REPAIR	$95
D2981	INLAY REPAIR	$95
D2982	ONLAY REPAIR	$95
D2983	VENEER REPAIR	$95
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	$29
ENDODONTIC SERVICES		
D3110	PULP CAP - DIRECT	$30
D3120	PULP CAP - INDIRECT	$30
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL JUNC	$40
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT TEETH	$95
D3222	PARTIAL PULPOTOMY	$75
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	$60
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	$55
D3310	ANTERIOR	$200
D3320	BICUSPID	$210
D3330	MOLAR	$310
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	$85
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	$75
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	$125
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	$350
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	$400
D3348	RETX PREVIOUS RC THERAPY - MOLAR	$480
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	$90
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	$90
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	$90
D3410	APICOECTOMY SURG - ANT	$190
D3421	APICOECTOMY SURG-BICUSPID	$315
D3425	APICOECTOMY SURG - MOLAR	$345
D3426	APICOECTOMY SURGERY	$100
D3428	BONE GRAFT WITH PERIRADICULAR SURGERY PER TOOTH	$47
D3429	BONE GRAFT WITH PERIRADICULAR SURGERY EACH ADDITIONAL TOOTH	$42
D3430	RETROGRADE FILLING - PER ROOT	$80
D3431	BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION	$150
D3432	GUIDED TISSUE REGENERATION, RESORBABLE BARRIER, PER SITE	$150
D3450	ROOT AMPUTATION - PER ROOT	$150
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$535
D3470	INTENTIONAL REIMPLANTATION (INCLUDING NECESSARY SPLINTING)	$175
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	$190
D3472	SURGICAL REPAIR OF ROOT RESORPTION -	$315
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR ROOT RESORPT-ANTERIOR	$235
D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR OF ROOT RESORPT-PREMOLAR	$235
D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR OF ROOT RESORPT-MOLAR	$235
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	$95
D3920	HEMISECTION NOT INCL RC THERAPY	$105
D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	$75
PERIODONTIC SERVICES		
D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	$180
D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD	$108
D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST PROC/TOOTH	$65
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$210
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$200
D4245	APICALLY POSITIONED FLAP	$150
D4249	CLIN CROWN LEN - HARD TISSUE	$240
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$375
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$325
D4263	BONE REPLACEMENT GRAFT - RETAINED NATURAL TOOTH - FIRST SITE IN QUADRANT	$450
D4264	BONE REPLACEMENT GRAFT - RETAINED NATURAL TOOTH - EACH ADDITIONAL SITE IN QUADRANT	$325
D4265	BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION	$325
D4266	GUIDED TISSUE REGENERATION - RESORBABLE BARRIER, PER SITE	$325
D4267	GUIDED TISSUE REGENERATION - NONRESORBABLE BARRIER, PER SITE (INCLUDES MEMBRANE REMOVAL)	$325
D4268	SURGICAL REVISION PROCEDURE, PER TOOTH	$0
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$290
D4273	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, 1ST TOOTH	$390
D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	$130
D4275	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, 1ST TOOTH	$502
D4276	COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT, PER TOOTH	$65
D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH	$215
D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD TOOTH	$75
D4283	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURIGCAL SITES - EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	$348
D4285	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURIGCAL SITES - EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	$392
D4320	PROVISIONAL SPLINTING - INTRACORONAL	$115
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	$105
D4341*	PERIODONTAL SCAL & ROOT PLAN 4/>TEETH-QUAD	$70t

	PREMOLAR		D4342*	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	$50t
D3473	SURGICAL REPAIR OF ROOT RESORPTION - MOLAR	$345			

ADA	DESCRIPTION	MEMBER PAYS
PERIODONTIC SERVICES		
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION - FULL MOUTH, AFTER ORAL EVALUATION	$60
D4355*	FULL MOUTH DEBRID COMP ORAL EVAL & DX ON A SUBSEQUENT VISIT	$60t
D4381*	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$65t
D4910*	PERIODONTAL MAINTENANCE	$65
D4920	UNSCHEDULED DRESSING CHANGE	$25
D4921	GINGIVAL IRRIGATION PER QUADRANT	$15
D4999	UNSPECIFIED PERIODONTAL PROCEDURE, BY REPORT	$0
REMOVABLE PROSTHODONTIC SERVICES		
D5110*	COMPLETE DENTURE - MAXILLARY	$440*
D5120*	COMPLETE DENTURE - MANDIBULAR	$440*
D5130*	IMMEDIATE DENTURE - MAXILLARY	$440*
D5140*	IMMEDIATE DENTURE - MANDIBULAR	$440*
D5211*	MAXILLARY PARTIAL DENTURE - RESIN BASE	$405*
D5212*	MANDIBULAR PARTIAL DENTURE - RESIN BASE	$405*
D5213*	MAX PART DENTUR-CAST METL W/RSN	$480*
D5214*	MAND PART DENTUR- CAST METL W/RSN	$480*
D5221*	IMMEDIATE MAXILLARY PARTIAL DENTURE - RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$425*
D5222*	IMMEDIATE MANDIBULAR PARTIAL DENTURE - RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$425*
D5223*	IMMEDIATE MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$500*
D5224*	IMMEDIATE MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$500*
D5225*	MAXILLARY PARTIAL DENTURE FLEX BASE	$480*
D5226*	MANDIBULAR PARTIAL DENTURE FLEX BASE	$480*
D5282*	REMOVABLE UNILATERAL PARTIAL DENTURE - MAXILLARY	$255*
D5283*	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	$255*
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$18
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	$18
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$18
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$18
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	$50*
D5512	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	$50*
D5520*	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	$40*
D5611*	REPAIR RESIN PARTIAL DENTURE BASE - MANDIBULAR	$40*
D5612*	REPAIR RESIN PARTIAL DENTURE BASE - MAXILLARY	$40*
D5621*	REPAIR CAST PARTIAL FRAMEWORK - MANDIBULAR	$50*
D5622*	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	$50*
D5630*	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	$70*
D5640*	REPLACE BROKEN TEETH - PER TOOTH	$40*
D5650*	ADD TOOTH EXISTING PARTIAL DENTURE	$60*
D5660*	ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	$70*
D5670*	REPLACE ALL TEETH & ACRYLC FRMEWRK MAXILLARY	$195*
D5671*	REPLACE ALL TEETH & ACRYLC FRMEWRK MANDIBULAR	$195*
D5710*	REBASE COMPLETE MAXILLARY DENTURE	$170*
D5711*	REBASE COMPLETE MANDIBULAR DENTURE	$170*
D5720*	REBASE MAXILLARY PARTIAL DENTURE	$160*
D5721*	REBASE MANDIBULAR PARTIAL DENTURE	$160*
D5730*	RELINE CMPL MAXIL DENTURE (DIRECT)	$100*
D5731*	RELINE CMPL MAND DENTURE (DIRECT)	$100*
D5740*	RELINE MAXIL PART DENTURE (DIRECT)	$90*
D5741*	RELINE MAND PART DENTURE (DIRECT)	$90*
D5750*	RELINE CMPL MAXIL DENTURE (INDIRECT)	$130*
D5751*	**RELINE CMPL MAND DENTURE (INDIRECT)**	**$130***
D5760*	RELINE MAXIL PART DENTURE (INDIRECT)	$130*
D5761*	RELINE MAND PART DENTURE (INDIRECT)	$130*
D5810*	INTERIM COMPLETE DENTURE (MAXILLARY)	$250*
D5811*	INTERIM COMPLETE DENTURE (MANDIBULAR)	$250*
D5820*	INTERIM PARTIAL DENTURE MAXILLARY	$160*
D5821*	INTERIM PARTIAL DENTURE MANDIBULAR	$160*
D5850	TISSUE CONDITIONING MAXILLARY	$40
D5851	TISSUE CONDITIONING MANDIBULAR	$40
D5862	PRECISION ATTACHMENT, BY REPORT	$150
D5899	UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT	$0
IMPLANT SERVICES		
D6010*	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$1,050
D6012*	SURGICAL PLACEMENT OF INTERIM IMPLANT BODY FOR TRANSITIONAL PROSTHESIS: ENDOSTEAL IMPLANT	$1,050
D6056*	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	$475
D6057*	CUSTOM FAB ABUTMENT - INCLUDES PLACEMENT	$595
D6058*	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$795
D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	$795
D6060*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	$795
D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	$795
D6062*	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$795
D6063*	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL)	$795
D6064*	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	$795
D6065*	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$795
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$795
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	$795
D6068*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	$795
D6069*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	$795
D6070*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	$795
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	$795

ADA	DESCRIPTION	MEMBER PAYS
IMPLANT SERVICES		
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	$795
D6073*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	$795
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	$795
D6075*	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$795
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$795
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL FPD-HIGH NOBLE ALLOYS	$795
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS	$180
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE	$70t
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$795
D6083	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS	$795
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$795
D6085	PROVISIONAL IMPLANT CROWN	$125
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE ALLOYS	$795
D6087	IMPLANT SUPPT CROWN-NOBLE ALLOYS	$795
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM ALLOYS	$795
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	$400
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	$45
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	$65
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	$795
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	$220
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	$500
D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$795
D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$795
D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	$795
D6100	IMPLANT REMOVAL, BY REPORT	$700
D6110*	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH - MAXILLARY	$1,300
D6111*	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	$1,300
D6112*	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	$1,040
D6113*	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH - MANDIBULAR	$1,040
D6114*	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH - MAXILLARY	$3,900
D6115*	IMPLANT /ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	$3,900
D6115*	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	$3,900
D6116*	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	$2,300
D6117*	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH - MANDIBULAR	$2,300
D6118	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	$1,840
D6119	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MAXILLARY	$1,840
D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$795
D6121	IMPLANT SUPPT RETAINER FOR METAL FPD-PREDOM. BASE ALLOYS	$795
D6122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	$795
D6123	IMPLANT SUPPT RETAINER FOR METAL FPD-TITANIUM/TITANIUM ALLOYS	$795
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	$235
FIXED PROSTHODONTIC SERVICES		
D6205*	PONTIC- INDIRECT RESIN BASED COMPOSITE	$695
D6210*	PONTIC - CAST HIGH NOBLE METAL	$290*
D6211*	PONTIC - CAST PREDOM BASE METAL	$290*
D6212*	PONTIC - CAST NOBLE METAL	$290*
D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	$290*
D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	$290*
D6241*	PONTIC - PORCELAIN FUSED PREDOM BASE METAL	$290*
D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	$290*
D6243	PONTIC-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$290*
D6245*	PONTIC - PORCELAIN/CERAMIC	$290*
D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	$290*
D6251*	PONTIC RESIN W/PREDOM BASE METAL	$290*
D6252*	PONTIC RESIN W/NOBLE METAL	$290*
D6253*	PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$0
D6545	RETAINER - CASE METAL FOR RESIN FIXED PROSTHESIS	$390
D6548*	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	$225*
D6600*	RETAINER INLAY - PORCELAIN/CERAMIC 2 SURFACES	$290*
D6601*	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$290*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	$290*
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/> SURFACES	$290*
D6604*	RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFACES	$290*
D6605*	RETAINER INLAY - CAST PREDOM BASE METAL 3/>SURFACES	$290*
D6606*	RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	$290*
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	$290*
D6608*	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	$290*
D6609*	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$290*
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURFACES	$290*
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	$290*
D6612*	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	$290*
D6613*	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	$290*

ADA	DESCRIPTION	MEMBER PAYS
FIXED PROSTHODONTIC SERVICES		
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	$290*
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	$290*
D6624*	RETAINER INLAY - TITANIUM	$290*
D6634*	RETAINER ONLAY - TITANIUM	$290*
D6710*	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$290*
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$290*
D6721*	RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	$290*
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	$290*
D6740*	RETAINER CROWN - PORCELAIN/CERAMIC	$290*
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$290*
D6751*	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$290*
D6752*	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$290*
D6753	RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$290*
D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$290*
D6781*	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$290*
D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	$290*
D6783*	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$290*
D6784	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	$290*
D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$290*
D6791*	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	$290*
D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	$290*
D6793*	PROVISIONAL RETAINER CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$125
D6794*	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	$290*
D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	$25
D6940	STRESS BREAKER	$125
D6950	PRECISION ATTACHMENT	$195
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	$80
ORAL SURGERY SERVICES		
D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	$60
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$30
D7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$80
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	$85
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	$90
D7240	REMOVAL IMPACTED TOOTH - COMPLETELY BONY	$135
D7241	REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	$150
D7250	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$40
D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL	$270
D7260	OROANTRAL FISTULA CLOSURE	$160
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$275
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	$80
D7272	TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND/OR STABILIZATION)	$100
D7280	EXPOSURE OF AN UNERUPTED TOOTH	$125
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	$125
D7283	PLACEMENT DEVICE FACILITATE ERUPT IMPACTED TOOTH	$80
D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	$145
D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	$95
D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$85
D7288	BRUSH BIOPSY	$25
D7291	TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT	$40
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$40
D7311	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	$40
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$125
D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	$125
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$370
D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	$990
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	$25
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	$50
D7412	EXCISION OF BENIGN LESION, COMPLICATED	$55
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$65
D7471	REMOVAL OF LATERAL EXOSTOSIS	$95
D7472	REMOVAL OF TORUS PALATINUS	$95
D7473	REMOVAL OF TORUS MANDIBULARIS	$95
D7485	REDUCTION OF OSSEOUS TUBEROSITY	$95
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	$20
D7511	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	$20
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	$20
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	$20
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	$35
D7921	COLLECTION AND APPLICATION OF AUTOLOGOUS BLOOD CONCENTRATE PRODUCT	$125
D7950	OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE	$350
	GRAFT OF THE MANDIBLE OR FACIAL BONES - AUTOGENOUS OR NONAUTOGENOUS, BY REPORT	
D7951	SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES VIA A LATERAL OPEN APPROACH	$800
D7952	SINUS AUGMENTATION VIA A VERTICAL APPROACH	$350
D7961	BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY)	$110
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	$110
D7963	FRENULOPLASTY	$110
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	$140
D7971	EXCISION OF PERICORONAL GINGIVA	$102
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	$125
ADJUNCTIVE GENERAL SERVICES		
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	$0
D9120	FIXED PARTIAL DENTURE SECTIONING	$0
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	$0
D9211	REGIONAL BLOCK ANESTHESIA	$0
D9212	TRIGEMINAL DIVISION BLOCK ANES	$0

D9215	LOCAL ANESTHESIA	$0

ADA	DESCRIPTION	MEMBER PAYS
ADJUNCTIVE GENERAL SERVICES		
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	$50
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	$50
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	$20
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	$65
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	$65
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	$15
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	$25
D9430	OV OBS - NO OTH SERVICES PERFORMED	$5
D9440	OV-AFTER REGULARLY SCHEDULED HRS	$35
D9450	CASE PRSATION DTL & EXT TX PLANNING	$0
D9610	THERAPEUTIC DRUG INJECTION, BY REPORT	$15
D9630	DRUGS OR MEDICAMENTS DISPENSED IN THE OFFICE FOR HOME USE	$15
D9910*	APPLICATION OF DESENSITIZING MEDICAMENT	$20
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	$0
D9932	CLEANING AND INSPECTION OF REMOVABLE COMPLETE DENTURE, MAXILLARY	$0
D9933	CLEANING AND INSPECTION OF REMOVABLE COMPLETE DENTURE, MANDIBULAR	$0
D9934	CLEANING AND INSPECTION OF REMOVABLE PARTIAL DENTURE, MAXILLARY	$0
D9935	CLEANING AND INSPECTION OF REMOVABLE PARTIAL DENTURE, MANDIBULAR	$0
D9942	REPAIR AND/OR RELINE OCCCLUSAL GUARDS	$40
D9943	OCCLUSAL GUARD ADJUSTMENT	$25
D9944*	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH	$250
D9945*	OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH	$250
D9946*	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH	$250
D9950	OCCLUSAL ANALYSIS - MOUNTED CASE	$75
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$30
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$125
D9973	EXTERNAL BLEACHING - PER TOOTH	$30
D9975	EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH	$240
D9986	MISSED APPOINTMENT	$25
D9991	DENTAL CASE MANAGEMENT - ADDRESSING APPOINTMENT COMPLIANCE BARRIERS	$0
D9992	DENTAL CASE MANAGEMENT - CARE COORDINATION	$0
D9993	DENTAL CASE MANAGEMENT - MOTIVATIONAL INTERVIEWING	$0
D9994	DENTAL CASE MANAGEMENT - PATIENT EDUCATION TO IMPROVE ORAL HEALTH LITERACY	$0
D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME ENCOUNTER	$0
D9996	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO DENTIST FOR SUBSEQUENT REVIEW	$0
D9997	DENTAL CASE MGMT-PATIENTS W/ SPECIAL NEEDS	$0
ORTHODONTIC SERVICES		
D8210	REMOVABLE APPLIANCE THERAPY	$103
D8220	FIXED APPLIANCE THERAPY	$103
D8698	RECEM/REBOND FIXED RETAINER-MAXIL	$0
D8699	RECEM/REBOND FIXED RETAINER-MANDIB	$0

ADA	DESCRIPTION	MEMBER PAYS
FixedProsthedontics		
D5982*	SURGICAL STENT	$100*
D5987*	COMMISSURE SPLINT	$100
D5988*	SURGICAL SPLINT	$100

The following exclusions apply to this plan.

Exclusion:

1. Services not listed on the Schedule of Covered Dental Care Services are charged to you, Covered Person or Subscriber, at a 25% discount of the Network's Dental Providers Usual and Customary Fee.
2. Services provided by an out-of-Network General Dental Provider or out-of-Network Specialty Dental Provider without prior approval, except emergencies.

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

Language Assistance Services

We[1] provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-800-445-9090, or the toll-free member phone number listed on your dental plan ID card TTY 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.

ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। पर कॉल 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.*

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.

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

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

Receive Information about Your Plan and Benefits

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

ERISA Statement

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

Summary Plan Description

Name of Plan: DG3 NORTH AMERICA INC Welfare Benefit Plan

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

DG3 NORTH AMERICA INC
100 Burma Road
Jersey City, NJ 07305
(201) 793-5000

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): 22-2478136

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:

DG3 NORTH AMERICA INC
100 Burma Road
Jersey City, NJ 07305
(201) 793-5000

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

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

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

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

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

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

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

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