

UnitedHealthcare PPO Dental
UnitedHealthcare Insurance Company
Certificate of Coverage

FOR: St of NC State Retirement Services

DENTAL PLAN NUMBER: P3271

ENROLLING GROUP NUMBER: 708788

EFFECTIVE DATE: January 1, 2016

Offered and Underwritten by
UnitedHealthcare Insurance Company

UnitedHealthcare Insurance Company

Dental Certificate of Coverage

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

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

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

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

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

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

Read your Certificate Carefully

This is a legal contract between the policyholder and the Company

This Certificate is not a Medicare Supplement Certificate. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the Company.

Important Cancellation Information. Please read the provision entitled "Termination of Coverage" in Section 3 of this Certificate.

Introduction to Your Certificate

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

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

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

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

How To Use This Certificate

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

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

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

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

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

Network and Non-Network Benefits

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

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

Non-Network Benefits - These benefits apply when you decide to obtain Dental Services from Non-Network Dentists. *Section 10: Procedures for Obtaining Benefits* describes the procedures for obtaining Covered Dental Services as Non-Network Benefits. Unless otherwise noted in the *Schedule of Covered*

Dental Services or *Section 11: Covered Dental Services*, Non-Network Benefits generally require you to pay more than Network Benefits. Non-Network Benefits are determined based on the Usual and Customary fee for similarly situated Network Dentists for each Covered Dental Service. The actual charge made by a Non-Network Dentist for a Covered Dental Service may exceed the Usual and Customary fee. As a result, you may be required to pay a Non-Network Dentist an amount for a Covered Dental Service in excess of the Usual and Customary fee. In addition, when you obtain Covered Dental Services from Non-Network Dentists, you must file a claim with the Company to be reimbursed for Eligible Expenses.

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

Dental Services Covered Under the Policy

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

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

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

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

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

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

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

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

Important Note About Services

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

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

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

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

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

Important Information Regarding Medicare

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

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

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

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

Identification ("ID") Card

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

Contact the Company

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

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Section 1: Definitions

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

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

Congenital Anomaly - a physical developmental defect that is present at birth.

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

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

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

Deductible – the amount a Covered Person must pay for Dental Services in a calendar year before the Company will begin paying for Benefits in that calendar year.

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

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

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

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

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

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

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

The term "foster child" means a minor (i) over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina; or (ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

The term "placement in the foster home" means physically residing with a person appointed as guardian or custodian of a foster child as long as that guardian or custodian has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the guardian or custodian on more than a temporary or short-term basis.

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

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

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

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

- A. For Network Benefits, when Covered Dental Services are received from Network Dentists, Eligible Expenses are the Company's contracted fee(s) for Covered Dental Services with that provider.
- B. For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dentists, Eligible Expenses are the Usual and Customary fees as defined below.

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

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

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

Employee - a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

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

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

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

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

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

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

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

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

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

- A. necessary to meet the basic dental needs of the Covered Person; and
- B. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service; and
- C. consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; and
- D. consistent with the diagnosis of the condition; and
- E. required for reasons other than the convenience of the Covered Person or his or her Dentist; and
- F. demonstrated through prevailing peer-reviewed dental literature to be either:

1. safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
2. safe with promising efficacy
 - a. for treating a life threatening dental disease or condition; and
 - b. in a clinically controlled research setting; and
 - c. using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

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

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

In-Network Covered Services - Covered Dental Services that are received according to the rules of the health benefit plan from Dentists employed by, under contract with, or approved in advance by the insurer; and means emergency health care services regardless of the status or affiliation of the provider of such services.

Out-of-Network Covered Services - means non-emergency, medically necessary covered health care services that are not received according to the rules of the health benefit plan, including services from affiliated providers that are received without the approval of the insurer.

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

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

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

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

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

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

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

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

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

Usual and Customary - Usual and Customary fees are calculated by the Company based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the provider would charge any similarly situated payor for the same services. In the event that a provider routinely waives Copayments and/or the Deductible for benefits, Dental Services for which the Copayments and/or the Deductible are waived are not considered to be Usual and Customary.

Usual and Customary fees are determined solely in accordance with the Company's reimbursement policy guidelines. The Company's reimbursement policy guidelines are developed by the Company, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association);
- As reported by generally recognized professionals or publications;
- As utilized for Medicare;
- As determined by medical or dental staff and outside medical or dental consultants;
- Pursuant to other appropriate source or determination accepted by the Company.

Section 2: Enrollment and Effective Date of Coverage

Section 2.1 Enrollment

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

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

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

Section 2.2 Effective Date of Coverage

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

If an Eligible Person enrolls during the Initial Eligibility Period, Coverage is effective on the first day of the policy month following the month in which the Eligible Person joins the Enrolling Group.

Section 2.3 Coverage for a Newly Eligible Person

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

Section 2.4 Coverage for a Newly Eligible Dependent

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

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption or foster home will be effective upon the date of birth or the date of placement in the adoptive/foster home. If additional monthly premiums are required, you must notify the Company and pay the required premium within 31 days of acquiring the new Dependent. If no additional monthly premium will be required, a newborn child will be covered from the moment of birth. A foster care or adopted child will be covered from the date of placement in the home provided coverage for that child is put into effect within 31 days.

Section 2.5 Change in Family Status

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

Section 2.6 Special Enrollment Period

An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period or Open Enrollment Period may enroll for Coverage during a special enrollment period. A special enrollment period is available if the following conditions are met: (a.) the Eligible Person and/or Dependent had existing health coverage under another plan at the time of the Initial Eligibility Period or Open Enrollment Period; and (b.) Coverage under the prior plan was terminated as a result of loss of eligibility (including, without limitation, legal separation, divorce or death), termination of employer contributions, or in the case of COBRA continuation coverage, the coverage was exhausted. A special enrollment period is not available if coverage under the prior plan was terminated for cause or as a result of failure to pay Premiums on a timely basis. Coverage under the Policy is effective only if the Company receives any required Premium and a properly completed enrollment form within 31 days of the date coverage under the prior plan terminated. A special enrollment period is also available for an Eligible Person and for any Dependent whose status as a Dependent is affected by a marriage, birth, placement for adoption or adoption, as required by federal law. In such cases you must submit the required Premium and a properly completed enrollment form within 31 days of the marriage, birth, placement for adoption or adoption.

Section 3: Termination of Coverage

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

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

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

- A. The date the entire Policy is terminated, as specified in the Policy. The Enrolling Group is responsible for notifying you 45 days in advance of the termination of the Policy.
- B. The date you cease to be eligible as a Subscriber or Enrolled Dependent.
- C. The date the Company receives written notice from either the Subscriber or the Enrolling Group instructing the Company to terminate Coverage of the Subscriber or any Covered Person or the date requested in such notice, if later.
- D. The date the Subscriber is retired or pensioned under the Enrolling Group's Plan, unless a specific Coverage classification is specified for retired or pensioned persons in the Enrolling Group's application and the Subscriber continues to meet any applicable eligibility requirements.

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

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

Section 3.2 Extended Coverage for Handicapped Dependent Children

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

- A. the Enrolled Dependent becomes incapacitated prior to attainment of the limiting age; and

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

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

Section 3.3 Extended Coverage

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

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

Section 3.4 Payment and Reimbursement Upon Termination

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

Section 4: Reimbursement

Section 4.1 Reimbursement of Eligible Expenses

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

Section 4.2 Filing Claims for Reimbursement of Eligible Expenses

You are responsible for sending a request for reimbursement to the Company's office, or our authorized agent, on a form provided by or satisfactory to the Company. Requests for reimbursement should be submitted within 180 days after date of service. Unless you are legally incapacitated, failure to provide this information to the Company within 1 year of the date of service will cancel or reduce Coverage for the Dental Service.

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

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

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

Proof of Loss. Written proof of loss should be given to the Company, or our authorized agent, within 180 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service.

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

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

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

If any payment payable to the your estate or to a beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay an amount not exceeding \$3,000 to any relative by blood or connection by marriage of the insured or beneficiary deemed to be equitably entitle. Such a payment shall discharge the Company from all further liability to the extent of the payment made.

Section 4.3 Limitation of Action for Reimbursement

You do not have the right to bring any legal proceeding or action against the Company to recover reimbursement until 60 days after you have properly submitted a request for reimbursement, as described above. If you do not bring such legal proceeding or action against the Company within 3 years from the date satisfactory written proof of loss was submitted to us, you forfeit your rights to bring any action against the Company.

Section 5: Complaint Procedures

Section 5.1 Complaint Resolution

If you have a concern or question regarding the provision of Dental Services or benefits under the Policy, you should contact the Company's customer service department at the telephone number shown on your ID card. Customer service representatives are available to take your call during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail. A customer service representative will return your call. If you would rather send your concern to us in writing at this point, the Company's authorized representative can provide you with the appropriate address.

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

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

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

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

Section 5.2 Complaint Hearing

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

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

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

Section 5.3 Exceptions for Emergency Situations

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

- The appeal does not need to be submitted in writing. You or your Dentist should call us as soon as possible.

- We will notify you of the decision by the end of the next business day after your complaint is received, unless more information is needed.
- If we need more information from your Dentist to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

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

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

Section 6: General Provisions

Section 6.1 Entire Policy

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

Section 6.2 Limitation of Action

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

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

Section 6.3 Time Limit on Certain Defenses

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

Section 6.4 Amendments and Alterations

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

Section 6.5 Relationship Between Parties

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

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

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

Section 6.6 Information and Records

At times the Company may need additional information from you. You agree to furnish the Company with all information and proofs that the Company may reasonably require regarding any matters pertaining to

the Policy. If you do not provide this information when the Company requests it we may delay or deny payment of your Benefits.

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

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

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

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

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

Section 6.7 Examination of Covered Persons

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

Section 6.8 Clerical Error

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

Section 6.9 Notice

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

Section 6.10 Workers' Compensation Not Affected

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

Section 6.11 Conformity with Statutes

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

Section 6.12 Waiver/Estoppel

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

Section 6.13 Headings

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

Section 6.14 Unenforceable Provisions

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

Section 7: Coordination of Benefits

Section 7.1 Coordination of Benefits Applicability

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

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

Section 7.2 Definitions

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

- A. A "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
1. "Plan" includes: true group insurance. This includes prepayment, group practice or individual practice coverage and Medicare or other governmental benefits, as permitted by law.
 2. "Plan" does not include: franchise individual insurance; blanket, school accident type coverage; automobile and homeowner coverage; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

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

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

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

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

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

Section 7.3 Order of Benefit Determination Rules

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

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

- 2.) The parents are not separated (whether or not they ever have been married); or
- 3.) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

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

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

Section 7.4 Effect on the Benefits of This Coverage Plan

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

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

- B. If a covered person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB will not apply between that Coverage Plan and other closed panel Coverage Plans.

- C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the primary Coverage Plan.

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

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

Section 7.5 Right to Receive and Release Needed Information

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

Section 7.6 Payments Made

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

Section 7.7 Right of Recovery

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

covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Section 8: Refund of Expenses

Refund of Overpayments. If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if:

- A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person,
- B. All or some of the payment made by the Company exceeded the benefits under the Policy, or
- C. All or some of the payment was made in error.

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

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Enrolling Group. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Reimbursement of Benefits Paid. If the Company pays benefits for expenses incurred on account of a Covered Person, the Subscriber or any other person or organization that was paid must make a refund to the Company if all or some of the expenses were recovered from or paid by a source other than the Policy as a result of claims against a third party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount the Company paid.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Enrolling Group. The reduction will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Section 9: Continuation of Coverage

Section 9.1 Continuation Coverage

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

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

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

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

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

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

Section 9.2 Continuation Coverage Under Federal Law

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

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

Section 9.3 Qualifying Events for Continuation Coverage Under Federal Law

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

- A. Termination of the Subscriber from employment with the Enrolling Group (for any reason other than gross misconduct) or reduction of hours; or
- B. Death of the Subscriber; or
- C. Divorce or legal separation of the Subscriber; or
- D. Loss of eligibility by an Enrolled Dependent who is a child; or

- E. Entitlement of the Subscriber to Medicare benefits; or
- F. The Enrolling Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents. This is also a qualifying event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

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

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

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

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

Section 9.5 Terminating Events for Continuation Coverage Under Federal Law

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

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

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

- B. Thirty-six months from the date of the Qualifying Event for an Enrolled Dependent whose Coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, loss of eligibility by an Enrolled Dependent who is a child, in accordance with qualifying events (B.), (C.), or (D.) described in *Section 9.3*.

- C. For the Enrolled Dependents of a Subscriber who was entitled to Medicare prior to a Qualifying Event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the Qualifying Event, or if later, 36 months from the date of the Subscriber's Medicare entitlement.
- D. The date Coverage terminates under the Policy for failure to make timely payment of the Premium.
- E. The date, after electing continuation Coverage, that coverage is obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition of the Qualified Beneficiary, continuation will end on the date such limitation or exclusion ends. The other group health coverage will be primary for all health services except those health services that are subject to the preexisting condition limitation or exclusion.
- F. The date, after electing continuation Coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this will not apply in the event the Qualified Beneficiary's Coverage was terminated because the Enrolling Group filed for bankruptcy, in accordance with qualifying event (F.) described in *Section 9.3*.
- G. The date the entire Policy ends.
- H. The date Coverage would otherwise terminate under the Policy.

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

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

Section 10: Procedures for Obtaining Benefits

Section 10.1 Dental Services

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

Network Benefits

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

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

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

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

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

Non-Network Benefits

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

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

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

Network Dentists

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

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

Covered Persons are issued an identification card (ID card) showing they are eligible for Network discounts. A Covered Person must show this ID card every time Dental Services are given. This is how

the provider knows that the patient is Covered under a Network plan. Otherwise, the person could be billed for the provider's normal charge.

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

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

Section 10.2 Pre-Treatment Estimate

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

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

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

Section 11: Covered Dental Services

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

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

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

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

Network Benefits:

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

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

Non-Network Benefits:

When Copayments are charged as a percentage of Usual and Customary fees, the amount you pay for Dental Services from Non-Network providers is determined as a percentage of the Usual and Customary fee plus the amount by which the Non-Network provider's billed charge exceeds the Usual and Customary fee.

Deductible

Deductible is \$25 per Covered Person per calendar year.

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

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

Maximum Benefit

Maximum Benefit is \$1,000 per Covered Person per calendar year.

Maximum Benefit applies to any combination of the following Covered Dental Services: DIAGNOSTIC SERVICES, PREVENTIVE SERVICES, MINOR RESTORATIVE SERVICES, ENDODONTICS,

PERIODONTICS, ORAL SURGERY, ADJUNCTIVE SERVICES, MAJOR RESTORATIVE SERVICES, FIXED PROSTHETICS, REMOVABLE PROSTHETICS.

If a Covered Person has claims for Covered Dental Services in a calendar year of less than \$500 an additional \$250 will be added to the Maximum Benefit in the next calendar year and an additional \$100 will be added to the Maximum Benefit in the next calendar year when only Network Benefits are utilized up to a limit of \$1,250 additional Maximum Benefit.

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

- a.) the Covered Person has submitted a claim for an Eligible Expense incurred during the preceding calendar year; and
- b.) the reimbursement for the Eligible Expense incurred in the preceding calendar year did not exceed the benefit threshold.

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

- a.) during any calendar year, Eligible Expenses are reimbursed in excess of the threshold. In this instance, there will be no additional carry over amount for the calendar year; or
- b.) during any calendar year, no claims for Eligible Expenses incurred during the preceding calendar year are submitted. In this instance, there will be no carry over amount for the calendar year, any accumulated carry over amounts from previous calendar year will be forfeited.

Eligibility for the carry over amount will be established or reestablished at the time for the first claim in a calendar year is received for Eligible Expenses incurred during the calendar year. In order to properly calculate the carry over amount, claims should be submitted timely in accordance with the proof of loss provision found within *Section 4: Reimbursement*.

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

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

Section 11.1 CREDIT FOR PRIOR COVERAGE

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

Section 12: General Exclusions

Section 12.1 Exclusions

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

- A. Dental Services that are not Necessary.
- B. Hospitalization or other facility charges.
- C. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- D. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body. This exclusion does not apply to dental care associated with Congenital Anomaly for an insured Dependent child who is covered from the moment of birth or placement in the adoptive or foster home.
- E. Any Dental Procedure not directly associated with dental disease.
- F. Any Dental Procedure not performed in a dental setting.
- G. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- H. Placement of dental implants, implant-supported abutments and prostheses.
- I. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- J. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or any order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- K. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- L. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision. This exclusion does not apply to dental care associated with Congenital Anomaly for an insured Dependent child who is covered from the moment of birth or placement in the adoptive or foster home.
- M. Replacement of complete dentures, and fixed and removable partial dentures or crowns, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

- N. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
- O. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
- P. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
- Q. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- R. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- S. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- T. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
- U. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- V. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
- W. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
- X. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- Y. Orthodontic Services.
- Z. In the event that a Non-Network Dentist routinely waives Copayments and/or the Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Deductible are waived is reduced by the amount waived by the Non-Network provider.
- AA. Foreign Services are not Covered unless required as an Emergency.
- BB. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- CC. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.

SCHEDULE OF COVERED DENTAL SERVICES

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT	NON-NETWORK COPAYMENT
	is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
DIAGNOSTIC SERVICES		
Bacteriologic Cultures	0%	0%
Viral Cultures	0%	0%
Intraoral Bitewing Radiographs Limited to 1 series of films per calendar year.	0%	0%
Panorex Radiographs Covered 1 time per consecutive 60 months.	0%	0%
Oral/Facial Photographic Images Limited to 1 time per consecutive 36 months.	0%	0%
Diagnostic Casts Limited to 1 time per consecutive 24 months.	0%	0%
Extraoral Radiographs Limited to 2 films per calendar year.	0%	0%
Intraoral - Complete Series (including bitewings) Limited to 1 series of films per calendar year.	0%	0%
Intraoral Periapical Radiographs	0%	0%
Pulp Vitality Tests Limited to 1 charge per visit, regardless of how many teeth	0%	0%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
are tested.		
Intraoral Occlusal Film	0%	0%
Periodic Oral Evaluation Covered 2 times per calendar year.	0%	0%
Comprehensive Oral Evaluation Covered 2 times per calendar year.	0%	0%
Limited or Detailed Oral Evaluation Covered 2 times per calendar year.	0%	0%
Comprehensive Periodontal Evaluation - new or established patient Limited to 2 times per consecutive 12 months.	0%	0%
Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures Limited to 1 time per consecutive 12 months.	0%	0%
PREVENTIVE SERVICES		
Dental Prophylaxis Covered 2 times per calendar year.	0%	0%
Fluoride Treatments - child Limited to covered persons	0%	0%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
under the age of 19 years and limited to 2 times per calendar year.		
Sealants Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	0%	0%
Space Maintainers Limited to Covered Persons under the age of 14 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	0%	0%
Re-Cement Space Maintainers Limited to 1 per consecutive 6 months after initial insertion.	0%	0%
MINOR RESTORATIVE SERVICES		
Amalgam Restorations Once per tooth every 24 months.	50%	50%
Composite Resin Restorations - Anterior Once per tooth every 24 months.	50%	50%
Gold Foil Restorations Once per tooth every 24 months.	50%	50%
ENDODONTICS		
Apexification Limited to 1 time per tooth per lifetime.	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Apicoectomy and Retrograde Filling Limited to 1 time per tooth per lifetime.	50%	50%
Hemisection Limited to 1 time per tooth per lifetime.	50%	50%
Root Canal Therapy Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	50%	50%
Retreatment of Previous Root Canal Therapy Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	50%	50%
Root Resection/Amputation Limited to 1 time per tooth per lifetime.	50%	50%
Therapeutic Pulpotomy Limited to 1 time per primary or secondary tooth per lifetime.	50%	50%
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration) Limited to 1 time per tooth per lifetime. Covered for anterior or posterior teeth only.	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Pulp Caps - Direct/Indirect - excluding final restoration Not covered if utilized solely as a liner or base underneath a restoration.	50%	50%
Pulpal Debridement, Primary and Permanent Teeth Limited to 1 time per tooth per lifetime. This procedure is not to be used when endodontic services are done on same date of service.	50%	50%
PERIODONTICS		
Crown Lengthening Limited to 1 per quadrant or site per consecutive 36 months.	50%	50%
Gingivectomy/Gingivoplasty Limited to 1 per quadrant or site per consecutive 36 months.	50%	50%
Gingival Flap Procedure Limited to 1 per quadrant or site per consecutive 36 months.	50%	50%
Osseous Graft Limited to 1 per quadrant or site per consecutive 36 months.	50%	50%
Osseous Surgery Limited to 1 per quadrant or site per consecutive 36 months.	50%	50%
Guided Tissue Regeneration Limited to 1 per quadrant or site	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
per consecutive 36 months.		
Soft Tissue Surgery Limited to 1 per quadrant or site per consecutive 36 months.	50%	50%
Periodontal Maintenance Limited to 2 times per calendar year.	50%	50%
Full Mouth Debridement Limited to once per consecutive 36 months.	50%	50%
Provisional Splinting Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.	50%	50%
Scaling and Root Planing Limited to 1 time per quadrant per consecutive 24 months.	50%	50%
Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report Limited to 3 sites per quadrant, or 12 sites total, for refractory pockets, or in conjunction with scaling or root planing, by report.	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
ORAL SURGERY		
Alveoloplasty	50%	50%
Biopsy Limited to 1 biopsy per site per visit.	50%	50%
Frenectomy/Frenuloplasty	50%	50%
Surgical Incision Limited to 1 per site per visit.	50%	50%
Removal of a Benign Cyst/Lesions Limited to 1 per site per visit.	50%	50%
Removal of Torus Limited to 1 per site per visit.	50%	50%
Root Removal, Surgical Limited to 1 time per tooth per lifetime.	50%	50%
Simple Extractions Limited to 1 time per tooth per lifetime.	50%	50%
Surgical Extraction of Erupted Teeth or Roots Limited to 1 time per tooth per lifetime.	50%	50%
Surgical Extraction of Impacted Teeth Limited to 1 time per tooth per lifetime.	50%	50%
Surgical Access, Surgical	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Exposure, or Immobilization of Unerupted Teeth Limited to 1 time per tooth per lifetime.		
Primary Closure of a Sinus Perforation Limited to 1 per tooth per lifetime.	50%	50%
Placement of Device to Facilitate Eruption of Impacted Tooth Limited to 1 time per tooth per lifetime.	50%	50%
Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report Limited to 1 time per tooth per lifetime.	50%	50%
Vestibuloplasty Limited to 1 time per site per consecutive 60 months.	50%	50%
Bone Replacement Graft for Ridge Preservation - per site Limited to 1 per site per lifetime Not Covered if done in conjunction with other bone graft replacement procedures.	50%	50%
Excision of Hyperplastic Tissue or Pericoronal Gingiva Limited to 1 per site per consecutive 36 months.	50%	50%
Appliance Removal (not by dentist who placed appliance) includes removal of arch bar	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Limited to once per appliance per lifetime.		
Tooth Reimplantation and/or Transplantation Services Limited to 1 per site per lifetime.	50%	50%
Oroantral Fistula Closure Limited to 1 per site per visit.	50%	50%
ADJUNCTIVE SERVICES		
Analgesia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	50%	50%
Desensitizing Medicament	50%	50%
General Anesthesia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	50%	50%
Local Anesthesia Not Covered in conjunction with operative or surgical procedure.	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
<p>Intravenous Sedation and Analgesia</p> <p>Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.</p>	50%	50%
<p>Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report</p> <p>Limited to 1 per visit.</p>	50%	50%
<p>Occlusal Adjustment</p>	50%	50%
<p>Occlusal Guards</p> <p>Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.</p>	50%	50%
<p>Occlusal Guard Reline and Repair</p> <p>Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.</p>	50%	50%
<p>Occlusion Analysis - Mounted Case</p> <p>Limited to 1 time per consecutive 60 months.</p>	50%	50%
<p>Palliative Treatment</p> <p>Covered as a separate benefit</p>	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
only if no other services, other than exam and radiographs, were done on the same tooth during the visit.		
<p>Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.)</p> <p>Not Covered if done with exams or professional visit.</p>	50%	50%
<p>MAJOR RESTORATIVE SERVICES</p> <p>Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.</p>		
<p>Coping</p> <p>Limited to 1 per tooth per consecutive 60 months. Not Covered if done at the same time as a crown on same tooth.</p>	50%	50%
<p>Crowns - Retainers/Abutments</p> <p>Limited to 1 time per tooth per consecutive 60 months. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.</p>	50%	50%
<p>Crowns - Restorations</p> <p>Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.</p>	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Temporary Crowns - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%	50%
Inlays/Onlays - Retainers/Abutments Limited to 1 time per tooth per 60 consecutive months. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%	50%
Inlays/Onlays - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%	50%
Pontics Limited to 1 time per tooth per consecutive 60 months.	50%	50%
Retainer-Cast Metal for Resin Bonded Fixed Prosthesis Limited to 1 time per tooth per consecutive 60 months.	50%	50%
Pin Retention Limited to 2 pins per tooth; not covered in addition to cast	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
restoration.		
Post and Cores Covered only for teeth that have had root canal therapy.	50%	50%
Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core Limited to those performed more than 12 months after the initial insertion.	50%	50%
Sedative Filling Covered as a separate benefit only if no other service, other than x-rays and exam, were done on the same tooth during the visit.	50%	50%
Stainless Steel Crowns Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	50%	50%
FIXED PROSTHETICS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Fixed Partial Dentures (Bridges) Limited to 1 time per tooth per consecutive 60 months.	50%	50%
REMOVABLE PROSTHETICS		

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	NON-NETWORK COPAYMENT is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Full Dentures Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	50%	50%
Partial Dentures Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	50%	50%
Relining and Rebasing Dentures Limited to 1 time every 36 months.	50%	50%
Tissue Conditioning - Maxillary or Mandibular Limited to 1 time per consecutive 12 months.	50%	50%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	50%	50%

Dependent Coverage Amendment

UnitedHealthcare Insurance Company

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

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

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

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

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

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

The term "foster child" means a minor (i) over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina; or (ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

The term "placement in the foster home" means physically residing with a person appointed as guardian or custodian of a foster child as long as that guardian or custodian has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the guardian or custodian on more than a temporary or short-term basis.

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

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

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

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 Services have been received.

Pre-service Requests for Benefits

Pre-service requests for benefits are those requests that require notification or benefit confirmation prior to receiving Dental Services.

How to Request an Appeal

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

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- 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 appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a Dental Provider with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, dental experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent 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 relevant to your claim for benefits. In addition, 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.

Appeals Determinations

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

For procedures associated 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 be conducted 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 first level appeal will be conducted 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. We don't determine whether the pending Dental Service is necessary or appropriate. That decision is between you and your Dental Provider.

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 urgent appeal process applies only to pre-service requests.

HEALTH 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, 2015

We¹ 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 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, we will post the revised notice on your health plan website, such as www.myuhc.com or www.uhcwest.com. We reserve 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 enrollees' 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; and
- 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 necessary 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.

- **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 purposes 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 evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal 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 necessary 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 necessary (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 necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and 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. "Highly confidential information" may include confidential information under federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
 - ◆ 1. HIV/AIDS;
 - ◆ 2. Mental health;
 - ◆ 3. Genetic tests;
 - ◆ 4. Alcohol and drug abuse;
 - ◆ 5. Sexually transmitted diseases and reproductive health information; and
 - ◆ 6. Child or adult abuse or neglect, including sexual assault.

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. Attached to this notice is a "Federal and State Amendments" document.

Except for uses and disclosures described and limited as set forth 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, contact the phone number listed on your 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 modify 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 obtain 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 pursuant 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 obtain a copy of this notice on your health plan website, such as www.myuhc.com or www.uhcwest.com.

Exercising Your Rights

- **Contacting your Health 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 health plan ID card or you may contact a *UnitedHealth Group Customer Call Center* Representative at 1-866-633-2446, or TTY 711.
- **Submitting a Written Request.** Mail to us 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, 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.

¹This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; AmeriChoice of Georgia, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Maryland, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Citrus Health Care, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Evercare of Arizona, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

FINANCIAL INFORMATION PRIVACY NOTICE

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

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2015

We² are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means 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; and
- 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; and
- 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 health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-866-633-2446, or TTY 711.

²For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on page four of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; Dental Benefit Providers, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

HEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2015

The first part of this Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. show the categories of health information that are subject to these more restrictive laws; and
2. give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
We are not allowed to use genetic information for underwriting purposes.

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	CA, NE, PR, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS
Prescriptions	

We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and /or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, OH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, IL, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WV, WA, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect certain HIV/AIDS-related information only with your written consent.	OR
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who	WA

is the subject of the information.	
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI

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