Lincoln DentalConnect® DHMO Dental Plan

Evidence of Coverage

FOR: Denton ISD

DENTAL PLAN NUMBER: LDCTXV7

ENROLLING GROUP NUMBER: 00040D026423

EFFECTIVE DATE: SEPTEMBER 1, 2013

Offered and Underwritten by

National Pacific Dental, Inc.

National Pacific Dental, Inc.

1333 West Loop South

Suite 1100

Houston, Texas 77027

877-813-4259

DHMO Dental Plan

Dental Evidence of Coverage

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

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

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

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

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

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

Introduction

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

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

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

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

How To Use This EOC

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

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

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

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

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

Dental Services Covered Under the Contract

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

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

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

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

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

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

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

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

Important Note About Services

The Company does not provide Dental Services or practice dentistry. Rather, the Company arranges for providers of Dental Services to participate in a Network. Participating Dentists are independent practitioners and are not employees of the Company. The Company compensates its' providers using direct reimbursement, discounted fee for service, fee for service and capitation. The dentist also receives compensation from Company enrollees who pay a defined "Copayment" for specific Dental Services. In addition, there may be occasions when a program may provide supplemental payments for specific Dental Procedures. These arrangements may include financial incentives to promote the delivery of dental care in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to Necessary Dental Services.

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

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

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

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

Important Information Regarding Medicare

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

Identification ("ID") Card

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

Contact the Company

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

IMPORTANT NOTICE

You may call our toll-free telephone number for information or to make a complaint at 888-877-7828

You may also write to:

1445 North Loop West

Suite 500

Houston, TX 77008

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at (800) 252-3439.

You may write the Texas Department of Insurance at:

P. O. Box 149104

Austin, TX 78714-9104

FAX: (512) 475-1771

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact us first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Usted puede llamar nuestro número de teléfono de peaje-liberta para la información o para formular una queja en 888-877-7828.

Usted también puede escribir a nosotros en:

1445 North Loop West

Suite 500

Houston, TX 77008

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de companias, coberturas, derechos o quejas al (800) 252-3439.

Puede escribir al Departamento de Seguros de Texas:

P. O. Box 149104

Austin, TX 78714-9104

FAX: (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Debele tiene una disputa con respecto a su prima o acerca de un reclamo usted nos debe contactar primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU CERTIFICADO:

Este aviso es solo para propósito de información y no se convierte en parte o condicion del documento adjunto.

Table of Contents

Section 1: Definitions

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

Adverse Determination - a determination by a utilization review agent that dental services provided or proposed to be provided to an enrollee are not dentally or medically necessary or are experimental or investigational.

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

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

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

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

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

Copayment - the charge you are required to pay for certain Dental Services payable under the Contract. A Copayment is a defined dollar amount. You are responsible for the payment of any Copayment directly to the provider of the Dental Service at the time of service or when billed by the provider.

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

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

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

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

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

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

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

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

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

Domestic Partner - a person 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. 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 Contract is in effect, are the Company's contracted fee(s) for Covered Dental Services with that Dentist.

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

Emergency - procedures administered in a dentist’s office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive

bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

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

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

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

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

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

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

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

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

Full-time Student - a person who is enrolled in and attending, full-time, a recognized course of study or training at:

A. An accredited high school;

B. An accredited college or university; or

C. A licensed vocational school, technical school, beautician school, automotive school or similar training school.

A health benefit plan that requires as a condition of coverage for a child 25 years of age or older, that the child be a full-time student at an educational institution must provide the coverage:

1. for the entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student; and

2. continuously until the 10th day of instruction of the subsequent academic term, on which date the health benefit plan may terminate coverage for the child if the child does not return to full-time student status before that date.

For purposes of this section, determination of the full-time student status of a child is made in the manner provided by the educational institution at which the child is enrolled.

A person continues to be a Full-time Student during periods of regular vacation established by the institution. If the person does not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end on the last day of the calendar year in which the person was enrolled and in attendance at the institution on a full-time basis.

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

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

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

A. necessary to meet the basic dental needs of the Covered Person; and

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

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

D. consistent with the diagnosis of the condition; and

E. required for reasons other than the convenience of the Covered Person or his or her Dentist; and

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

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

    2. safe with promising efficacy

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

        b. in a clinically controlled research setting; and

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

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

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

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

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

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

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

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

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

Plan Year - The period of time, usually beginning with the Contract's effective date of any year and terminating on the same date of the succeeding year, when accumulators for Deductibles and plan maximums are calculated. If the Contract effective date is February 29, such date will be considered to be February 28 in any year having no such date.

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

Primary Care Dentist (PCD) - a Participating Dentist providing Covered Dental Services to Covered Persons who has been selected by a Covered Person and assigned by Us to provide and arrange for his or her Dental Services. Enrollees with chronic, disabling, or life threatening illnesses may apply to Our medical director to utilize a non-primary care physician specialist as a primary care physician.

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

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

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

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

Section 2: Enrollment and Effective Date of Coverage

Section 2.1 Enrollment

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

If you enroll for Coverage under the Contract, 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 date 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 reason of birth, legal adoption, legal guardianship, placement for adoption, court or administrative order, or marriage will take effect on the date of the event. Coverage is effective only if the Company receives any required Premium and is notified of the event within 31 days.

Section 2.5 Change in Family Status

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

Section 2.6 Special Enrollment Period

An Eligible Person and/or Dependent who did not enroll for Coverage under the Contract during the Initial Eligibility Period or Open Enrollment Period may enroll for Coverage during a special enrollment period. A special enrollment period is available if the following conditions are met: (a.) the Eligible Person and/or Dependent had existing health coverage under another plan at the time of the Initial Eligibility Period or

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

Section 3: Termination of Coverage

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

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

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

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

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

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

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

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

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

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

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

H. The date specified by the Company that your Coverage will terminate because you failed to pay a required Copayment.

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

Section 3.2 Extended Coverage for Handicapped Dependent Children

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

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

B. proof of such incapacity and dependence is furnished to the Company within 31 days of the date the Subscriber receives a request for such proof from the Company; and

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

Coverage will be continued so long as the Enrolled Dependent continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Contract. 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 Contract.

Section 3.3 Services in Progress When Coverage Ends

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

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

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

Section 3.4 Extended Coverage

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

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

Section 3.5 Reinstatement of the Contract After Termination

If the Contract is terminated for the Enrolling Group's nonpayment of Premiums, the Company will permit reinstatement of the Contract once during any 12-month period if the Enrolling Group pays the amounts owed within 15 days of the date the Company mails the notice confirming termination.

Section 4: Reimbursement

Section 4.1 If You Get A Bill

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

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

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

If the Services you received are covered by the Texas Department of Human Services ("DHS"), the Company will reimburse DHS.

If there is a court order providing for the managing conservator of a minor child, the Company will reimburse the conservator on the Subscriber's behalf.

Section 4.2 Your Billing Protection

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

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

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

Section 4.3 Payment of Claims

Claims are processed within 30 business days of receipt. Processing includes payment or denial of the claim, notification of investigation of the claim and requests for any additional information from the member that we reasonably believe necessary to resolve a claim. Not later than the 15th business day after receipt of all information necessary to process the claim, we notify the member in writing of acceptance or rejection of a claim. We give the reason(s) for a rejected claim; the reason for needing additional time to make a determination of a claim and we make payment of damages if payment on a claim is delayed following receipt of all necessary items. We will pay the claim, or part of the claim, not later than the 5th business day after notifying the member that the claim will be paid.

Section 5: Complaint Procedures

Section 5.1 Complaint Resolution

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

If 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 30 days of receiving it. If you are not satisfied with our decision, you have the right to take your complaint to the Texas Department of Insurance.

Section 5.2 Complaint Hearing

If you request a hearing, you have a right to appear in person before a complaint appeal panel at the site at which you normally receive health care services or at another site agreed to by you, or you can address a written appeal to the compliant appeal panel. 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.

If we do not resolve your complaint to your satisfaction, you have the right to appeal our decision, either verbally or in writing, to our Complaint Appeal Panel. You may appeal by: (a) appearing in person before the Complaint Appeal Panel in a location where you normally receive dental services, or at a different location to which you agree; or (2) presenting a written appeal to the Complaint Appeal Panel. When you appeal your complaint:

1. We will send an acknowledgement letter to you within five (5) business days after the date we receive your request for an appeal.
2. We will appoint members to the Complaint Appeal Panel, which advises us on the resolution of the appeal. The members of the Complaint Appeal Panel cannot have been involved with your complaint in the past. The Complaint Appeal Panel will include an equal number of our staff, dentists, and enrollees (who are not employed by the HMO). The providers on the appeal panel must have experience in the area of care that is in dispute and must be independent of the provider who made any previous determination.

3. Not later than the 5th business day before the Complaint Appeal Panel meets, we will provide to you or your designated representative:

    a. any documentation that will be presented to our participants of the Complaint Appeal Panel;

    b. the specialization of any Dentist consulted during the investigation of your appeal; and

    c. the name, specialty, and affiliation of each of the members of the Complaint Appeal Panel.

You, or your designated representative, if you are a minor or are disabled, have the right to:

1. appear in person before the Complaint Appeal Panel;

2. present alternative expert testimony; and

3. request the presence of, and to question, any person that was involved in making the prior determination that resulted in your appeal.

We will complete the appeals process not later than the 30th calendar day after we receive your appeal. Our final decision on the appeal will include a statement of the specific dental determination, clinical basis, and contractual criteria used to reach the final decision.

If the appeal request involves a presently occurring dental care emergency, we will investigate and resolve such appeal in accordance with the degree of emergency of the case, but no later than one (1) business day after you have made your request for appeal. At your request, we will provide, instead of a Complaint Appeal Panel, an independent review by a Dentist who has not reviewed the case and who is of the same or similar specialty as ordinarily manages the procedure or treatment under appeal. The Dentist reviewing the appeal may interview you or your designated representative and will make a decision on the appeal. Initial notice of the decision on the appeal may be delivered orally to you but will be followed by a written notice of the determination within three (3) business days. Appeals for determinations will be handled in the same manner.

Your failure to comply with these procedures, and the procedures outlined in the Member Rights and Plan Responsibilities provided with the acknowledgement letter, will result in the original decision being upheld, with no further action on such complaint.

We will send an acknowledgement letter to You no later than the fifth business day after the date the written request for the appeal is received.

We will complete the appeals process not later than the 30th calendar day after the date the written request for appeal is received. If you are not satisfied with our decision, you have the right to take your complaint to the Texas Department of Insurance.

The Company will not engage in retaliatory action, including refusal to renew or cancellation of coverage, against an Enrolling Group because the Group or Eligible Person, or person acting on behalf of the Enrolling Group or Eligible Person has filed a complaint against the Company or appealed a decision of the Company.

The Company will not engage in retaliatory action, including refusal to renew or termination of a contract, against a physician or provider because the physician or provider has, on behalf of an Eligible Person, reasonably filed a complaint against the Company or appealed a decision of the Company.

Section 5.3 Adverse Determinations

An Eligible Person, a person acting on behalf of an Eligible Person, or an Eligible Person's provider of record may initiate the appeal. The Company will send an acknowledgment letter of the receipt of oral or written appeal of adverse determination from complainants no later than five working days after the date of the receipt of the appeal. This letter will include a description of the appeal procedures and time frames, as well as a reasonable list of documents needed to be submitted by the complainant for the appeal. If the appeal is received orally, The Company will also enclose a one-page appeal form, which

will aid in prompt resolution of the appeal. The Eligible Person is not required to return this letter in order to process the appeal. The Company will respond to the Eligible Person, person acting on behalf of the Eligible Person, or the Eligible Person's provider of record as soon as possible but not later than 30 days after receipt of the appeal. If the appeal is denied, and within ten working days the provider sets forth in writing good cause for having a particular type of specialty provider review the case, the denial shall be reviewed by a health care provider in the same or similar specialty as typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review of the adverse determination, and such specialty review shall be completed within 15 working days of receipt of the request.

In a circumstance involving an Eligible Person's life-threatening condition, the Eligible Person is entitled to an immediate appeal to an Independent Review Organization and is not required to comply with internal appeal of an adverse determination procedures. The plan permits any party whose appeal of an adverse determination is denied to seek review by an Independent Review Organization assigned to the appeal in accordance with Chapter 4202 of the Texas Insurance Code.

The plan will provide the IRO no later than three business days after the date of request by the IRO:

1. a copy of:
    a. any medical records of the Eligible Person that are relevant to the review;
    b. any documents used by the plan in making the determination to be reviewed;
    c. the written notification described by Section 4201.359; and
    d. any documents and other written information submitted to the agent in support of the appeal; and
2. a list of each physician or other health care provider who:
    a. has provided care to the Eligible Person; and
    b. may have medical records relevant to the appeal.

And finally, the plan will comply with the IRO's determination with respect to the medical necessity or appropriateness of health care items and services for an Eligible Person, or the determination regarding the experimental or investigational nature of health care items and services for an Eligible Person.

Section 5.4 Expedited Appeal Procedure for Emergency Situations

Your appeal requires immediate actions when your Dentist judges that a delay in treatment would significantly increase the risk to your health, or for denials of emergency care, care for life-threatening conditions or continued stays for hospitalized patients. 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 one working day from the date your appeal 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 one working day from the date the required information is received.

The appeal process for urgent situations does not apply to prescheduled treatments or procedures that are not urgent situations.

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

Section 6: General Provisions

Section 6.1 Entire Contract

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

Section 6.2 Limitation of Action

You do not have the right to bring any legal proceeding or action against the Company until 61 days after you have properly submitted a request for reimbursement. If you do not bring such legal proceeding or action against the Company within 3 years of the date the Company notified you of its final decision as described in *Section 5: Complaint Procedures*; you forfeit your rights to bring any action against the Company.

Section 6.3 Time Limit on Certain Defenses

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

Section 6.4 Amendments and Alterations

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

Section 6.5 Relationship Between Parties

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

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

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

Section 6.6 Information and Records

At times the Company may need additional information from you. You agree to furnish the Company with all information and proofs that the Company may reasonably require regarding any matters pertaining to the Contract. If you do not provide this information when the Company requests it we may delay or deny payment of your Benefits.

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

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

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

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

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

Section 6.7 ERISA

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

Section 6.8 Examination of Covered Persons

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

Section 6.9 Clerical Error

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

Section 6.10 Notice

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

Section 6.11 Workers' Compensation Not Affected

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

Section 6.12 Conformity with Statutes

Any provision of the Contract which, on its effective date, is not in conformity with the requirements of state or federal statutes or regulations will not be rendered invalid, but will be construed and applied as if it were in full compliance with the Insurance Code Chapter 1271 and other applicable laws.

Section 6.13 Waiver/Estoppel

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

Section 6.14 Headings

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

Section 6.15 Unenforceable Provisions

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

Section 7: Coordination of Benefits

Section 7.1 Coordination of Benefits Applicability

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

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

Section 7.2 Definitions

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

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

   1. "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.

   2. "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

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

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

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

C. "Allowable expense" means a health care service or expense, including deductibles and Copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example a dental HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

   1. If a person is covered by 2 or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.

2. If a person is covered by 2 or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

3. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the primary Coverage Plan's payment arrangements will be the allowable expense for all Coverage Plans.

D. "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.

E. "Closed panel Coverage Plan" is a Coverage Plan that provides health or dental benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Section 7.3 Order of Benefit Determination Rules

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

A. The primary Coverage Plan pays or provides its benefits as if the secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage will be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.

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

D. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

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

2. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Coverage Plan is:

a. The primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:

1.) The parents are married;

2.) The parents are not separated (whether or not they ever have been married); or

3.) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

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

b. If the specific terms of a court decree state that one of the parents is responsible for the child's health or dental care expenses or health or dental care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or Coverage Plan years commencing after the Coverage Plan is given notice of the court decree.

c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

1.) The Coverage Plan of the custodial parent;

2.) The Coverage Plan of the spouse of the custodial parent;

3.) The Coverage Plan of the noncustodial parent; and then

4.) The Coverage Plan of the spouse of the noncustodial parent.

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D.(1.).

4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, Subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.

5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, Subscriber or retiree longer is primary.

6. If the preceding rules do not determine the primary Coverage Plan, the allowable expenses will be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

Section 7.4 Effect on the Benefits of This Coverage Plan

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

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

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

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

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

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

Section 7.5 Right to Receive and Release Needed Information

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

Section 7.6 Payments Made

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

Section 7.7 Right of Recovery

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

Section 8: Subrogation

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. The Company will be subrogated to and will succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits provided by the Company to you from: (i.) third parties, including any person alleged to have caused you to suffer injuries or damages; (ii.) your employer; or (iii.) any person or entity obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties"). You agree to assign to the Company all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits provided by the Company, plus reasonable costs of collection.

You will cooperate with the Company in protecting the Company's legal rights to subrogation and reimbursement, and acknowledge that the Company's rights will be considered as the first priority claim against Third Parties, to be paid before any other claims by you are paid. You will do nothing to prejudice the Company's rights under this provision, either before or after the need for services or benefits under the Contract. The Company may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in your name. For the reasonable value of services provided under the Contract, the Company may collect, at its option, amounts from the proceeds of any settlement (whether before or after any determination of liability) or judgment that may be recovered by you or your legal representative, regardless of whether or not you have been fully compensated. You will hold in trust any proceeds of settlement or judgment for the benefit of the Company under these subrogation provisions and the Company will be entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you. You will not accept any settlement that does not fully compensate or reimburse the Company without the written approval of the Company. You agree to execute and deliver such documents (including a written confirmation of assignment, and consents to release dental records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as may be reasonably requested by the Company.

Section 9: Continuation of Coverage

Section 9.1 Continuation Coverage

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

A Covered Person who is eligible for continuation coverage under COBRA, is entitled to six additional months following any period of continuation.

A Covered Person who is not eligible for continuation coverage under COBRA, is entitled to nine months Continuation Coverage.

Continuation Coverage for Covered Persons who selected continuation coverage under a prior plan which was replaced by Coverage under the Contract will terminate as scheduled under the prior plan or in accordance with the terminating events set forth in *Section 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 Contract 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, and on the due date of each payment thereafter. Following the first payment made after the initial election for coverage, the payment of any other premium shall be considered timely if made by the thirtieth 30th day after the date on which payment is due.

Section 9.5 Terminating Events for Continuation Coverage Under Federal Law

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

A. Eighteen months from the date of a Qualifying Event for a Qualified Beneficiary whose Coverage would have otherwise ended due to termination of employment (for reasons other than gross misconduct) or a reduction in hours. A Qualified Beneficiary who is determined to be disabled at the time during the first 60 days of continuation Coverage may extend continuation Coverage to a maximum of 29 months from the date of the Qualifying Event described in *Section 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 Contract for failure to make timely payment of the Premium.

E. The date, after electing continuation Coverage, that coverage is obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition of the Qualified Beneficiary, continuation will end on the date such limitation or exclusion ends. The other group health coverage will be primary for all health services except those health services that are subject to the preexisting condition limitation or exclusion.

F. The date, after electing continuation Coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this will not apply in the event the Qualified Beneficiary's Coverage was terminated because the Enrolling Group filed for bankruptcy, in accordance with qualifying event (F.) described in *Section 9.3*.

G. The date the entire Contract ends.

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

If a Qualified Beneficiary is entitled to 18 months of continuation and a second Qualifying Event occurs during that time, the continuation Coverage of a Qualified Beneficiary who is an Enrolled Dependent may be extended up to a maximum of 36 months from the Qualifying Event described in *Section 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 *EOC* if such Dental Services are Necessary and are provided by or under the direction of a Dentist or other provider. All Coverage is subject to the terms, conditions, exclusions and limitations of the Contract.

Subscribers choose a Dentist from a list of Participating Dentists provided by the dental plan, who will become the Subscriber's "Primary Care Dentist." Your Primary Care Dentist will be the one you call when you need dental advice and when you need preventive care. A Covered Person can also call to determine which providers participate in the Network. The telephone number for customer Service is on the ID card.

Within the Service Area, you are entitled to receive all the Dental Services specified in the *Schedule of Covered Dental Services* and *Section 11: Covered Dental Services* of this *EOC*. You must go to your Participating Dentist for these services unless the dental plan has made prior special arrangements for you. If you do not use a Participating Dentist and the dental plan has not approved the use of a Non-Participating Dentist you will not be Covered for any services received.

If medically necessary covered services are not available through our Network of Dentists, we shall, upon the request of a Network Dentist, within the time appropriate to the Enrollee's dental condition but not exceeding five (5) days, allow a referral to a non-network dentist, and shall fully reimburse the non-network dentist at the usual and customary fee, or an agreed-upon rate.

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

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

Coverage for Dental Services is subject to payment of the Premium required for Coverage under the Contract and payment of the Copayment specified for any service shown in the *Schedule of Covered Dental Services* and *Section 11: Covered Dental Services*.

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

Prohibited Referral

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

Missed Appointments

When an appointment is made with a Participating Dentist, you are expected to honor such appointment. If you do not cancel the appointment at least 24 hours in advance, you will be charged a fee for each half-hour segment of the missed appointment for which the Company shall not be liable.

Section 10.2 Selecting a Primary Care Dentist

This plan is designed to provide quality dental care while controlling the cost of this care. Covered Persons must seek Dental Services from a Participating Dentist. Except for Emergency Dental Services, in no event will we cover Dental Services provided to a Covered Person by a Non-Participating Dentist. The Network includes Participating Dentists in a Covered Person's geographic area. A "Participating Dentist" is a Dentist that has a provider agreement in force with us. When a Covered Person enrolls in this plan, he or she will get information about our current Participating Dentists. Each Covered Person must select a Primary Care Dentist (PCD) from the list of Participating Dentists who will be responsible for coordinating all of the Covered Person's dental care. If you have any further questions regarding provider location, office hours or emergency hours or other providers in your area, or to request a copy of the provider directory, you may contact customer service at the telephone number on your ID card to receive that information. You can also find an online version of the directory at www.myuhcdental.com.

After enrollment, a Covered Person will receive an ID card. A Covered Person can schedule an appointment by simply calling the Dentist and must present this ID card when he or she goes to his or her PCD. All Dental Services Covered by this plan must be coordinated by the Covered Person's PCD whom the Covered Person selects and is assigned to upon enrolling in this plan. Please read your materials carefully for specific benefit levels, exclusions, Coverage limits and Covered Person Copayments. You can call our customer service department at the telephone number on your ID card if you have any questions after reading your materials

Section 10.3 Changing Your Primary Care Dentist

You may transfer to another Primary Care Dentist (PCD) if you have no Procedure in Progress. All Procedures in Progress started at your current PCD should be completed before a change, unless a quality-of-care issue is identified. If you wish to select another Dentist, you may contact the customer service department at the telephone number on your ID card. If you elect to change offices without completing Procedures In Progress, you may be responsible for all billed charges by your new PCD. If you owe your PCD any money, you will be asked to settle your account at the time you transfer.

We review transfer requests on a case-by-case basis. If you meet the above requirements and call us by the 20th of the current month, your transfer will be effective on the first day of the following month. If you meet the criteria but your request is received after the 20th of the current month, your transfer will be effective the first day of the second succeeding month. For example, if you meet the above requirements and you call us on June 17th to request a new PCD, the transfer will be effective on July 1st. If you meet the above requirements and you call us on June 21st, the transfer will be effective August 1st.

A provider is required to copy and deliver your complete patient file upon your request. A provider may charge you a reasonable fee for the copying and delivery of your records.

If a Network Provider is not available within a reasonable distance, but not more than 75 miles from your primary residence or primary workplace for specialty care, specialty hospitals, and single healthcare service plan physicians or providers. If medically necessary covered services are not available through our Network of Dentists, we shall, upon the request of a Network Dentist, within the time appropriate to the Enrollee's dental condition but not exceeding five (5) days, allow a referral to a non-network dentist, and shall fully reimburse the non-network dentist at the usual and customary fee, or an agreed-upon rate. For reimbursement procedure information, please contact the customer service department at the telephone number on your ID card.

Section 10.4 Changes in Dentist Participation

If: (a) the Dentist you selected is no longer a Participating Dentist in the Network; or (b) if we take an administrative action which affects the Dentist's participation in the Network, we may have to enroll you with a different Participating Dentist. If this occurs, you will have the opportunity to choose another Participating Dentist from among those in the Network. If you have a Dental Procedure in Progress when reassignment becomes necessary, we will, at your option and subject to applicable law, either: (a) arrange for completion of the services by the original PCD, if he or she agrees: (i) to accept payment at the contracted fee; and (ii) to abide by all plan provisions; or (b) make reasonable and appropriate arrangements for another Participating Dentist to complete the service. We will send you written notice when we are aware that a Participating Dentist is no longer available to treat you.

When we change your Participating Dentist: Under special circumstances we may require that a Subscriber change his or her Participating Dentist. Generally, this happens at the request of the Participating Dentist after a material detrimental change in their relationship with a Subscriber. If this occurs, we will notify the Subscriber of the effective date of the change and we will transfer the Subscriber to another Participating Dentist, provided he or she is medically able and there is an alternative Participating Dentist.

Section 10.5 Emergency Dental Services

All contracted Primary Care Dentists (PCD) provide Emergency Dental Services twenty-four (24) hours a day, seven (7) days a week. You should contact your PCD, who will make arrangements for Emergency care. If you are unable to reach your PCD in an Emergency during normal business hours, emergency care is available and accessible 24 hours per day, seven days per week, without restrictions as to where the services are rendered. Please call our customer service department for instructions.

Procedures can be administered in a dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

Then, within 2 business days, you should call our customer service department to notify us of the Emergency claim.

Claims for Emergency Dental Services

To receive reimbursement, you do not have to submit a claim form. All you have to do is send us, within 90 days, the itemized bill, marked "PAID," along with a brief explanation of why the Emergency Dental Services were Necessary. We will provide reimbursement within 5 business days of receipt. We will reimburse you for the cost of the Emergency Dental Services, less any Copayment which may apply.

All reimbursement requests should be mailed to:

Lincoln Financial Group - Claims

P.O Box 30567

Salt Lake City, Utah 84130

Section 10.6 Specialty Referrals

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

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

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

1. A Covered Person's PCD must coordinate all Dental Services.

2. When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization.

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

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

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

6. If medically necessary covered services are not available through our Network of Dentists, we shall, upon the request of a Network Dentist, within the time appropriate to the Enrollee's dental condition but not exceeding five (5) days, allow a referral to a non-network dentist, and shall fully reimburse the non-network dentist at the usual and customary fee, or an agreed-upon rate.

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

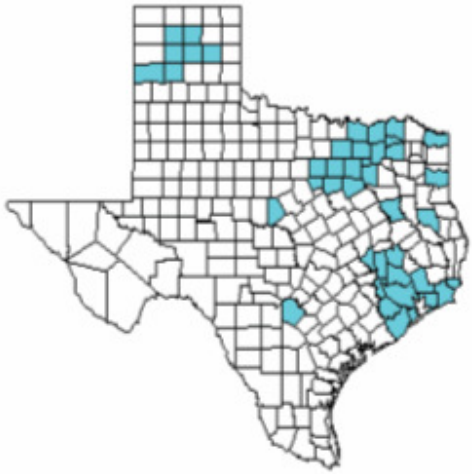
Section 10.7 Second Opinion Consultation

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

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

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

Texas Service Area



Anderson	Denton	Hunt	Potter
Bexar	Ellis	Hutchinson	Randall
Bowie	Fannin	Jefferson	Rockwall
Brazoria	Fort Bend	Johnson	Tarrant
Brazos	Galveston	Kaufman	Walker
Brown	Gray	Lamar	Waller
Carson	Grayson	Liberty	
Chambers	Grimes	Montgomery	
Collin	Harris	Moore	
Dallas	Harrison	Nacogdoches	
Deaf Smith	Hood	Orange	
Delta	Hopkins	Parker	

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 Necessary and not excluded as described in *Section 12: General Exclusions*.

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

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

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

Section 11.1 Covered Dental Services

Coverages for dental care services and benefits are services for the purposes of preventing, alleviating, curing, or healing dental disease, including dental and periodontal disease.

The following services are provided by a general dentist or hygienist, as applicable:

1. Office visit - during and after regularly scheduled hours;
2. Oral evaluations;
3. X-rays;
4. Bitewings;
5. Panoramic film;
6. Dental prophylaxis (adult and child);
7. Topical fluoride treatment for children;
8. Dental sealants for children;
9. Amalgam fillings (one, two, three and four or more surf, primary and permanent-including polishing);
10. Anterior resin filling (one, two, three and four or more surface or involving incisal angle, primary and permanent-including polishing);
11. Simple oral extractions;
12. Surgical incision and drainage of abscess-intraoral soft tissue; and
13. Palliative (emergency) treatment of dental pain.

Section 11.2 Additional Provisions

Multiple Crown/Bridge Unit Treatment Fee

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

Noble and High Noble Metals

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

Section 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 Contract, the following are not Covered:

A. Dental Services that are not Necessary.

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

C. Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the *Schedule of Covered Dental Services*.

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

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

F. Any Dental Procedure not performed in a participating dental setting. This will not apply to Covered Emergency Dental Services.

G. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

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

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

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

M. Replacement of complete dentures, 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. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

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

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

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

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

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

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

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

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

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

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

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

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

BB. Treatment which requires the services of a pediatric specialist, after the Covered Person’s 8th birthday.

CC. Consultations for non-Covered services.

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

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

FF. Relative analgesia (N2O2- nitrous oxide).

Section 12.2 Orthodontic Exclusions and Limitations

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

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

A. The following are not Covered orthodontic benefits:

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

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

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

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

E. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.

SCHEDULE OF COVERED DENTAL SERVICES

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
DIAGNOSTIC SERVICES		
D0120	Periodic Oral Evaluation Limited to 2 times per 12 months.	$0
D0140	Limited Oral Evaluation - Problem Focused	$0
D0150	Comprehensive Oral Evaluation - new or established patient Limited to 2 times per 12 months.	$0
D0160	Detailed and Extensive Oral Evaluation - Problem-Focused, by report Limited to 2 times per 12 months.	$0
D0170	Re-Evaluation, Limited, Problem Focused Limited to 2 times per 12 months.	$0
D0180	Comprehensive Periodontal Evaluation - new or established patient Limited to 2 times per 12 months.	$0
D0210	Intraoral - Complete Series (including bitewings) Limited to 1 time per 2 Plan Years.	$0
D0220	Intraoral - Periapical - First Film Limited to 1 per 12 months.	$0
D0230	Intraoral - Periapical - Each Additional Film Limited to 1 per 12 months.	$0
D0240	Intraoral Occlusal Film Limited to 1 per 12 months.	$0
D0250	Extraoral - First Film Limited to 1 per 12 months.	$0
D0260	Extraoral - Each Additional Film Limited to 1 per 12 months.	$0
D0270	Bitewing – Single Film Limited to 1 series of 4 films per 6 months.	$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
D0272	Bitewings - Two Films Limited to 1 series of 4 films per 6 months.	$0
D0273	Bitewings - Three Films Limited to 1 series of films per 6 months.	$0
D0274	Bitewings - Four Films Limited to 1 series of films per 6 months.	$0
D0277	Vertical Bitewings, 7-8 Films Limited to 1 series of films per 2 Plan Years.	$0
D0330	Panoramic Film Limited to 1 time per 2 Plan Years.	$0
D0415	Collection of Microorganisms for Culture and Sensitivity	$0
D0425	Caries Susceptibility Tests	$0
D0431	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 Covered Persons over the age of 30 years, and limited to 1 time per 12 months.	$20
D0460	Pulp Vitality Tests	$0
D0470	Diagnostic Casts	$0
D0472	Accession of tissue, gross exam, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic exam, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic exam, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0999	Office Visit Fee – Per Visit	$0
PREVENTIVE SERVICES		
D1110	Prophylaxis – adult Limited to 2 times per 12 months.	$0
D1110	Prophylaxis – adult Each additional prophylaxis within 6 months based upon the	$25

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
	necessity recommended by the Dentist.	
D1120	Prophylaxis – child Limited to 2 times per 12 months.	$0
D1120	Prophylaxis – child Each additional prophylaxis within 6 months based upon the necessity recommended by the Dentist.	$25
D1203	Topical Application of Fluoride (Prophylaxis Not Included) – child Limited to 1 time per calendar year.	$0
D1204	Topical Application of Fluoride (Prophylaxis Not Included) - adult Limited to 1 time per calendar year.	$0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients Limited to 1 time per calendar year.	$0
D1310	Nutritional Counseling for Control of Dental Disease	$0
D1320	Tobacco Counseling for Control and Prevention of Dental Disease	$0
D1330	Oral Hygiene Instructions	$0
D1351	Sealant - Per Tooth Limited to one per tooth.	$5
MINOR RESTORATIVE SERVICES		
D1510	Space Maintainer - Fixed - Unilateral	$20
D1515	Space Maintainer - Fixed - Bilateral	$20
D1520	Space Maintainer - Removable - Unilateral	$30
D1525	Space Maintainer - Removable - Bilateral	$30
D1550	Recementation of Space Maintainer	$5
D1555	Removal of fixed space maintainer	$10
D2140	Amalgam - One Surface, Primary or Permanent	$0
D2150	Amalgam - Two Surfaces, Primary or Permanent	$0
D2160	Amalgam - Three Surfaces, Primary or Permanent	$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	$0
D2330	Resin-Based Composite - One Surface, Anterior	$0
D2331	Resin-Based Composite - Two Surfaces, Anterior	$0
D2332	Resin-Based Composite - Three Surfaces, Anterior	$0
D2335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)	$0
D2391	Resin-Based Composite - One Surface, Posterior	$35
D2392	Resin-Based Composite - Two Surfaces, Posterior	$45
D2393	Resin-Based Composite - Three Surfaces, Posterior	$55
D2394	Resin-Based Composite - Four or More Surfaces, Posterior	$65
CROWNS/INLAYS/ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 5 Plan Years from initial or supplemental placement.		
D2390	Resin-Based Composite Crown, Anterior Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$25
D2510	Inlay - Metallic - One Surface Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$135
D2520	Inlay - Metallic -Two Surfaces Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$135
D2530	Inlay - Metallic - Three or More Surfaces Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$135
D2542	Onlay - Metallic - Two Surfaces Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$135
D2543	Onlay – Metallic - Three Surfaces Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$135
D2544	Onlay – Metallic - Four or More Surfaces	$135

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
	Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	
D2610	Inlay - Porcelain/Ceramic – One Surface Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2620	Inlay - Porcelain/Ceramic - Two Surfaces Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2630	Inlay - Porcelain/Ceramic - Three or More Surfaces Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2642	Onlay - Porcelain/Ceramic - Two Surfaces Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2643	Onlay - Porcelain/Ceramic - Three Surfaces Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2644	Onlay - Porcelain/Ceramic - Four or More Surfaces Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2650	Inlay - Composite/Resin - One Surface Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2651	Inlay - Composite/Resin - Two Surfaces Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2652	Inlay - Composite/Resin - Three Or More Surfaces Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2662	Onlay - Composite/Resin - Two Surfaces Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2663	Onlay - Composite/Resin - Three Surfaces Limited to 1 time per tooth per 5 Plan Years. Covered only	$150

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
	when a filling cannot restore the tooth.	
D2664	Onlay - Composite/Resin - Four Or More Surfaces Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2710	Crown - Resin-Based Composite (indirect) Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$115
D2712	Crown - 3/4 Resin-Based Composite (indirect) Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$115
D2720	Crown - Resin With High Noble Metal Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2721	Crown - Resin With Predominantly Base Meta Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2722	Crown - Resin With Noble Metal Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2740	Crown - Porcelain/Ceramic Substrate Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$210
D2750	Crown - Porcelain Fused To High Noble Metal Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2751	Crown - Porcelain Fused To Predominantly Base Metal Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2752	Crown - Porcelain Fused To Noble Metal Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2780	Crown - 3/4 Cast High Noble Metal Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
D2781	Crown - 3/4 Cast Predominately Base Metal Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2782	Crown - 3/4 Cast Noble Metal Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2783	Crown - 3/4 Porcelain/Ceramic Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2790	Crown - Full Cast High Noble Metal Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2791	Crown - Full Cast Predominantly Base Metal Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2792	Crown - Full Cast Noble Metal Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2794	Crown – titanium Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$150
D2910	Recement Inlay, Onlay Or Partial Coverage Restoration	$0
D2915	Recement Cast Or Prefabricated Post And Core	$0
D2920	Recement Crown	$0
D2930	Prefabricated Stainless Steel Crown - Primary Tooth Limited to 1 time per tooth per 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.	$30
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth Limited to 1 time per tooth per 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.	$30
D2932	Prefabricated Resin Crown	$25

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
	Limited to 1 time per tooth per 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.	
D2933	Prefabricated Stainless Steel Crown With Resin Window Limited to 1 time per tooth per 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.	$30
D2940	Sedative Filling	$0
D2950	Core Buildup, including any pins Limited to one per tooth.	$15
D2951	Pin Retention - Per Tooth, in addition to Restoration	$8
D2952	Cast Post and Core in addition to Crown Limited to teeth that have had root canal therapy.	$30
D2953	Each Additional Cast Post, Same Tooth Limited to teeth that have had root canal therapy.	$15
D2954	Prefabricated Post and Core in addition to Crown Limited to teeth that have had root canal therapy.	$10
D2955	Post Removal (Not in Conjunction with Endodontic Therapy Limited to teeth that have had root canal therapy	$10
D2957	Each Additional Prefabricated Post, Same Tooth Limited to teeth that have had root canal therapy	$25
D2970	Temporary Crown (fractured tooth) Limited to 1 time per tooth per 5 Plan Years. Covered only when a filling cannot restore the tooth.	$0
D2971	Additional Procedures to Construct New Crown under Existing Partial Denture Framework	$35
ENDODONTICS		
D3110	Pulp Cap - Direct (excluding final restoration)	$0
D3120	Pulp Cap - Indirect (excluding final restoration)	$0
D3220	Therapeutic Pulpotomy (excluding final restoration)	$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
D3221	Pulpal Debridement, Primary and Permanent Teeth	$10
D3230	Pulpal Therapy (resorbable filling) - Anterior, Primary Tooth (excluding final restoration)	$15
D3240	Pulpal Therapy (resorbable filling) - Posterior, Primary Tooth (excluding final restoration)	$15
D3310	Root Canal Therapy - Anterior (excluding final restoration)	$55
D3320	Root Canal Therapy - Bicuspid (excluding final restoration)	$115
D3330	Root Canal Therapy - Molar (excluding final restoration)	$225
D3331	Treatment of Root Canal Obstruction, Non-Surgical Access	$65
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth	$65
D3333	Internal Root Repair of Performation Defects	$65
D3346	Retreatment of Previous Root Canal Therapy - Anterior	$80
D3347	Retreatment of Previous Root Canal Therapy – Bicuspid	$140
D3348	Retreatment of Previous Root Canal Therapy – Molar	$250
D3351	Apexification/Recalcification - Initial Visit (apical closure/calcific repair of perforations, root resorption, etc.)	$55
D3352	Apexification/Recalcification - Interim Medication Replacement	$55
D3353	Apexification/Recalcification - Final Visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resportion, etc.)	$55
D3410	Apicoectomy/Periradicular Surgery – Anterior Limited to 1 time per tooth per lifetime.	$75
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (first root)	$75
D3425	Apicoectomy/Periradicular Surgery - Molar (first root)	$75
D3426	Apicoectomy/Periradicular Surgery (each additional root)	$45
D3430	Retrograde Filling - Per Root	$45
D3450	Root Amputation - Per Root	$75
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	$10
D3920	Hemisection (including any root removal), not including Root Canal Therapy	$70

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
D3950	Canal Preparation and Fitting of Preformed Dowel or Post	$10
PERIODONTICS		
D4210	Gingivectomy or Gingivoplasty - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant Limited to 1 per quadrant or site per 36 months.	$90
D4211	Gingivectomy or Gingivoplasty - One to Three Contiguous Teeth or Bounded Teeth Spaces Per Quadrant Limited to 1 per quadrant or site per 36 months.	$65
D4240	Gingival Flap Procedure, including Root Planing - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant Limited to 1 per quadrant or site per 36 months.	$125
D4241	Gingival Flap Procedure - One to Three Contiguous Teeth or Bounded Teeth Spaces Per Quadrant Limited to 1 per quadrant or site per 36 months.	$75
D4245	Apically Positioned Flap Limited to 1 per quadrant or site per 36 months.	$140
D4249	Clinical Crown Lengthening - Hard Tissue Limited to 1 per quadrant or site per 36 months.	$95
D4260	Osseous Surgery (including flap entry and closure) - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant Limited to 1 per quadrant or site per 36 months.	$275
D4261	Osseous Surgery (including flap entry and closure) - One to Three Contiguous Teeth or Bounded Teeth Spaces Per Quadrant Limited to 1 per quadrant or site per 36 months.	$275
D4263	Bone Replacement Graft - First Site in Quadrant Limited to 1 per quadrant or site per 36 months.	$165
D4264	Bone Replacement Graft - each additional site in Quadrant Limited to 1 per quadrant or site per 36 months.	$90
D4270	Pedicle Soft Tissue Graft Procedure Limited to 1 per quadrant or site per 36 months.	$175

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
D4271	Free Soft Tissue Graft Procedure (including donor site surgery) Limited to 1 per quadrant or site per 36 months.	$202
D4274	Distal or Proximal Wedge Procedure (when not performed in conjunction with surgical procedures in the same anatomical area) Limited to 1 per quadrant or site per 36 months.	$45
D4341	Periodontal Scaling and Root Planing - Four or More Teeth Per Quadrant Limited to 4 quadrants per calendar year.	$35
D4342	Periodontal Scaling and Root Planing - One - Three Teeth Per Quadrant Limited to 4 quadrants per calendar year.	$35
D4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	$35
D4381	Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$55
D4910	Periodontal Maintenance Limited to 1 time per 6 months following active therapy, exclusive of gross debridement.	$25
D4920	Unscheduled Dressing Change (by someone other than treating Dentist)	$0
REMOVABLE DENTURES Replacement of complete dentures, fixed and removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 5 Plan Years from initial or supplemental placement.		
D5110	Complete Denture – Maxillary Limited to 1 per 5 Plan Years. No additional allowances for precision or semi-precision attachments.	$215
D5120	Complete Denture – Mandibular Limited to 1 per 5 Plan Years. No additional allowances for precision or semi-precision attachments.	$215
D5130	Immediate Denture – Maxillary Limited to 1 per 5 Plan Years. No additional allowances for precision or semi-precision attachments.	$225

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
D5140	Immediate Denture - Mandibular Limited to 1 per 5 Plan Years. No additional allowances for precision or semi-precision attachments.	$225
D5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and teeth) Limited to 1 per 5 Plan Years. No additional allowances for precision or semi-precision attachments.	$250
D5212	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth) Limited to 1 per 5 Plan Years. No additional allowances for precision or semi-precision attachments.	$250
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth) Limited to 1 per 5 Plan Years. No additional allowances for precision or semi-precision attachments.	$250
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth) Limited to 1 per 5 Plan Years. No additional allowances for precision or semi-precision attachments.	$250
D5225	Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth) Limited to 1 per 5 Plan Years. No additional allowances for precision or semi-precision attachments.	$325
D5226	Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth) Limited to 1 per 5 Plan Years. No additional allowances for precision or semi-precision attachments.	$325
D5281	Removable Unilateral Partial Denture - One Piece Cast Metal (including clasps and teeth) Limited to 1 per 5 Plan Years. No additional allowances for precision or semi-precision attachments.	$245
D5410	Adjust Complete Denture – Maxillary Limited to adjustments performed more than 6 months after the initial insertion.	$0
D5411	Adjust Complete Denture - Mandibular	$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
	Limited to adjustments performed more than 6 months after the initial insertion.	
D5421	Adjust Partial Denture – Maxillary Limited to adjustments performed more than 6 months after the initial insertion.	$0
D5422	Adjust Partial Denture – Mandibular Limited to adjustments performed more than 6 months after the initial insertion.	$0
D5510	Repair Broken Complete Denture Base Limited to adjustments performed more than 6 months after the initial insertion.	$15
D5520	Replace Missing or Broken Teeth - Complete Denture (each tooth) Limited to adjustments performed more than 6 months after the initial insertion.	$15
D5610	Repair Resin Denture Base Limited to adjustments performed more than 6 months after the initial insertion.	$15
D5620	Repair Cast Framework Limited to adjustments performed more than 6 months after the initial insertion.	$15
D5630	Repair or Replace Broken Clasp Limited to adjustments performed more than 6 months after the initial insertion.	$15
D5640	Replace Broken Teeth - Per Tooth Limited to adjustments performed more than 6 months after the initial insertion.	$15
D5650	Add Tooth to Existing Partial Denture Limited to adjustments performed more than 6 months after the initial insertion.	$15
D5660	Add Clasp to Existing Partial Denture Limited to adjustments performed more than 6 months after the initial insertion.	$15
D5670	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary)	$125

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
	Limited to adjustments performed more than 6 months after the initial insertion.	
D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular) Limited to adjustments performed more than 6 months after the initial insertion.	$125
D5710	Rebase Complete Maxillary Denture	$45
D5711	Rebase Complete Mandibular Denture	$45
D5720	Rebase Maxillary Partial Denture	$45
D5721	Rebase Mandibular Partial Denture	$45
D5730	Reline Complete Maxillary Denture (Chairside)	$25
D5731	Reline Complete Mandibular Denture (Chairside)	$25
D5740	Reline Maxillary Partial Denture (Chairside)	$25
D5741	Reline Mandibular Partial Denture (Chairside)	$25
D5750	Reline Complete Maxillary Denture (Laboratory)	$45
D5751	Reline Complete Mandibular Denture (Laboratory)	$45
D5760	Reline Maxillary Partial Denture (Laboratory)	$45
D5761	Reline Mandibular Partial Denture (Laboratory)	$45
D5820	Interim Partial Denture (Maxillary) Limited to 1 per 5 Plan Years. No additional allowances for precision or semi precision attachments.	$45
D5821	Interim Partial Denture (Mandibular) Limited to 1 per 5 Plan Years. No additional allowances for precision or semi precision attachments.	$45
D5850	Tissue Conditioning, Maxillary	$0
D5851	Tissue Conditioning, Mandibular	$0
BRIDGES (fixed partial dentures) Replacement of complete dentures, fixed and removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 5 Plan Years from initial or supplemental placement.		
D6210	Pontic - Cast High Noble Metal Limited to 1 time per tooth per 5 Plan Years.	$150

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
D6211	Pontic - Cast Predominantly Base Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6212	Pontic - Cast Noble Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6214	Pontic – Titanium Limited to 1 time per tooth per 5 Plan Years.	$150
D6240	Pontic - Porcelain Fused to High Noble Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6241	Pontic - Porcelain Fused to Predominantly Base Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6242	Pontic - Porcelain Fused to Noble Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6245	Pontic - Porcelain/Ceramic Limited to 1 time per tooth per 5 Plan Years.	$215
D6250	Pontic - Resin with High Noble Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6251	Pontic - Resin with Predominantly Base Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6252	Pontic - Resin with Noble Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6600	Inlay - Porcelain/Ceramic - Two Surfaces Limited to 1 time per tooth per 5 Plan Years.	$170
D6601	Inlay - Porcelain/Ceramic, Three or More Surfaces Limited to 1 time per tooth per 5 Plan Years.	$170
D6602	Inlay - Cast Metal, Two Surfaces Limited to 1 time per tooth per 5 Plan Years.	$135
D6603	Inlay - Cast High Noble Metal, Three or More Surfaces Limited to 1 time per tooth per 5 Plan Years.	$135
D6604	Inlay - Cast Predominantly Base Metal, Two Surfaces	$135

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
	Limited to 1 time per tooth per 5 Plan Years.	
D6605	Inlay - Cast Predominantly Base Metal, Three or More Surfaces Limited to 1 time per tooth per 5 Plan Years.	$135
D6606	Inlay - Cast Noble Metal - Two Surfaces Limited to 1 time per tooth per 5 Plan Years.	$135
D6607	Inlay - Cast Noble Metal - Three or More Surfaces Limited to 1 time per tooth per 5 Plan Years.	$135
D6608	Onlay - Porcelain/Ceramic - Two Surfaces Limited to 1 time per tooth per 5 Plan Years.	$180
D6609	Onlay - Porcelain/Ceramic - Three or More Surfaces Limited to 1 time per tooth per 5 Plan Years.	$180
D6610	Onlay - Cast High Noble Metal - Two Surfaces Limited to 1 time per tooth per 5 Plan Years.	$135
D6611	Onlay - Cast High Noble Metal - Three or More Surfaces Limited to 1 time per tooth per 5 Plan Years.	$150
D6612	Onlay - Cast Predominantly Base Metal -Two Surfaces Limited to 1 time per tooth per 5 Plan Years.	$150
D6613	Onlay - Cast Predominantly Base Metal - Three or More Surfaces Limited to 1 time per tooth per 5 Plan Years.	$150
D6614	Onlay - Cast Noble Metal - Two Surfaces Limited to 1 time per tooth per 5 Plan Years.	$150
D6615	Onlay - Cast Noble Metal- Three or More Surfaces Limited to 1 time per tooth per 5 Plan Years.	$150
D6624	Inlay – Titanium Limited to 1 time per tooth per 5 Plan Years.	$150
D6634	Onlay – Titanium Limited to 1 time per tooth per 5 Plan Years.	$150
D6720	Crown - Resin with High Noble Metal	$150

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
	Limited to 1 time per tooth per 5 Plan Years.	
D6721	Crown - Resin with Predominantly Base Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6722	Crown - Resin with Noble Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6740	Crown - Porcelain/Ceramic Limited to 1 time per tooth per 5 Plan Years.	$215
D6750	Crown - Porcelain Fused to High Noble Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6751	Crown - Porcelain Fused to Predominantly Base Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6752	Crown - Porcelain Fused to Noble Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6780	Crown - 3/4 Cast High Noble Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6781	Crown - 3/4 Cast Predominately Based Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6782	Crown - 3/4 Cast Noble Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6783	Crown - 3/4 Porcelain/Ceramic Limited to 1 time per tooth per 5 Plan Years.	$150
D6790	Crown - Full Cast High Noble Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6791	Crown - Full Cast Predominantly Base Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6792	Crown - Full Cast Noble Metal Limited to 1 time per tooth per 5 Plan Years.	$150
D6794	Crown – Titanium Limited to 1 time per tooth per 5 Plan Years.	$150

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
D6930	Recement Fixed Partial Denture	$0
D6940	Stress Breaker	$110
D6970	Cast Post and Core in addition to Fixed Partial Denture Retainer Covered only for teeth that have had root canal therapy.	$40
D6972	Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer Covered only for teeth that have had root canal therapy.	$25
D6973	Core Build Up for Retainer, including any Pins	$10
D6976	Each Additional Cast Post - Same Tooth Covered only for teeth that have had root canal therapy.	$35
D6977	Each Additional Prefabricated Post - Same Tooth Covered only for teeth that have had root canal therapy.	$35
ORAL SURGERY		
D7111	Extraction, Coronal Remnants - Deciduous Tooth	$0
D7140	Extraction, Erupted Tooth or Exposed Root (elevation and/or forceps removal)	$0
D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Sectioning of Tooth	$15
D7220	Removal of Impacted Tooth - Soft Tissue	$35
D7230	Removal of Impacted Tooth - Partially Bony	$50
D7240	Removal of Impacted Tooth - Completely Bony	$75
D7241	Removal of Impacted Tooth - Completely Bony, With Unusual Surgical	$95
D7250	Surgical Removal of Residual Tooth Roots (cutting procedure)	$25
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	$50
D7280	Surgical Access of an Unerupted Tooth	$85
D7282	Mobilization of Erupted or Malpositioned Tooth to aid Eruption	$85
D7285	Biopsy of Oral Tissue - Hard (bone, tooth)	$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
D7286	Biopsy of Oral Tissue - Soft (all others)	$0
D7288	Brush Biopsy – transepithelial sample collection	$0
D7310	Alveoloplasty In Conjunction With Extractions - Per Quadrant	$15
D7311	Alveoplasty In Conjunction With Extraction - One to Three Teeth or Tooth Spaces, Per Quadrant	$10
D7320	Alveoloplasty Not In Conjunction With Extractions - Per Quadrant	$30
D7321	Alveoplasty Not In Conjunction With Extraction - One to Three Teeth or Tooth Spaces, Per Quadrant.	$10
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)	$50
D7472	Removal of Torus Palatinus Limited to 1 per site per visit.	$35
D7473	Removal of Torus Mandibularis Limited to 1 per site per visit.	$35
D7485	Surgical Reduction of Osseous Tuberosity	$35
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue Limited to 1 per site per visit.	$15
D7511	Incision and Drainage of Abscess - Intraoral Soft Tissue - Complicated (includes drainage of multiple fascial spaces)	$15
D7910	Suture of Recent Small Wounds up to 5 cm	$15
D7960	Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure	$15
D7963	Frenuloplasty	$15
D7970	Excision of Hyperplastic Tissue - Per Arch	$25
D7971	Excision of Pericoronal Gingival	$20
D7972	Surgical Reduction of Fibrous Tuberosity	$85
ADJUNCTIVE SERVICES		
D9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure	$10
D9211	Regional Block Anesthesia	$0
D9212	Trigeminal Division Block Anesthesia	$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
D9215	Local Anesthesia in conjunction with operative or surgical procedures	$0
D9220	Deep Sedation/General Anesthesia - First 30 Minutes Covered when Necessary in conjunction with Covered Dental Services. Limited to Covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions). If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is medically/clinically Necessary. Covered for patients over age of 6 if it is medically/clinically Necessary.	$145
D9221	Deep Sedation/General Anesthesia - Each Additional 15 Minutes Covered when Necessary in conjunction with Covered Dental Services. Limited to Covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions). If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is medically/clinically Necessary. Covered for patients over age of 6 if it is medically/clinically Necessary.	$65
D9241	Intravenous Conscious Sedation/Analgesia - First 30 Minutes Covered when Necessary in conjunction with Covered Dental Services. Limited to Covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions). If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is medically/clinically Necessary. Covered for patients over age of 6 if it is medically/clinically Necessary.	$145
D9242	Intravenous Conscious Sedation/Analgesia - Each Additional 15 Minutes Covered when Necessary in conjunction with Covered Dental Services. Limited to Covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete	$65

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
	bony impactions). If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is medically/clinically Necessary. Covered for patients over age of 6 if it is medically/clinically Necessary.	
D9310	Consultation (diagnostic service provided by Dentist or Physician other than practitioner providing treatment)	$0
D9430	Office Visit – Observation (during office hours)	$5
D9440	Office Visit – after regularly scheduled hours	$35
D9450	Case Presentation, Detailed and Extensive Treatment Planning	$0
D9930	Treatment of Complications (post-surgical) - Unusual Circumstances, by report	$0
D9940	Occlusal Guard, by report	$100
D9951	Occlusal Adjustment - Limited	$25
D9952	Occlusal Adjustment – Complete	$75
D9972	External Bleaching – Per Arch Coverage for external bleaching is limited to the fabrication of bleaching trays for home application of a bleaching product. In-office techniques, such as those using light activated material, are excluded from coverage. Limited to 1 per arch per Plan Year.	$125
D9999	Broken Appointment	$10

ORTHODONTICS

Orthodontic services are subject to payment of any applicable Copayments.

Benefits will be paid in equal monthly installments on a schedule determined by the Enrolling Group over the course of the orthodontic treatment plan performed during a 24 month period, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.

Benefits end when the 24 month orthodontic treatment ends or the $500 orthodontic maximum is reached, whichever comes first. If a Covered Person or Dependent is age 16 or older, benefits may continue provided that:

1. Orthodontic treatment started while Covered Person or Dependent was under age 16 and Covered under this plan; and
2. Active orthodontic treatment continues; and
3. Coverage for orthodontic services remains in force under this plan; and

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	COPAYMENT is shown as a fixed dollar amount.
4. The Covered Person or Dependent continues to be Covered under this plan. If all of the above conditions are not met, orthodontic benefits will be paid only to the end of the third month in which Coverage ends, and only for charges incurred while Coverage was in force.		
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,895
D8080	Comprehensive orthodontic treatment of the adolescent dentition up to age 18	$1,895
D8090	Comprehensive orthodontic treatment of the adult dentition age 18 or older	$1,895
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$300
D8999	Start-up Fee (including exam, beginning records, x-rays, tracing, photos and models)	$250
D8999	Post treatment records Covered if required by your orthodontist.	$150

UNITEDHEALTHCARE DENTAL

NOTICE OF PRIVACY PRACTICES

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: April 14, 2003

We* 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.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider or health plan that related to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our web site www.uhcspecialtybenefits.com.

*For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following UnitedHealthcare entities: ACN Group of California, Inc.; All Savers Insurance Company; AmeriChoice of New Jersey, Inc; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, In.; Dental Benefit Providers of California, Inc.; Dental benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Dental Benefit Providers of New Jersey, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; Investors Guaranty Life Insurance Company; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Nevada Pacific Dental, Inc.; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Optimum Choice, Inc. of Pennsylvania; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; Pacific Union Dental, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; United HealthCare of Alabama, Inc.; United HealthCare of Arizona, Inc.; United HealthCare of Arkansas, Inc.; United HealthCare of Colorado, Inc.; United HealthCare of Florida, Inc.; United HealthCare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; United HealthCare of Kentucky, Ltd.; United HealthCare of Louisiana, Inc., UnitedHealthcare of the Mid-Atlantic, Inc.; United HealthCare of the Midlands, Inc.; United HealthCare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; United HealthCare of Ohio, Inc.; United HealthCare of Tennessee, Inc.; United HealthCare of Texas, Inc.; United HealthCare of Utah; UnitedHealthcare of Wisconsin, Inc.; United HealthCare Insurance Company; United HealthCare Insurance Company of Illinois; United HealthCare Insurance Company of New York; United HealthCare Insurance Company of Ohio; and U.S. Behavioral Health Plan, California.

How We Use or Disclose Information

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

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

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

- ***For Payment*** of premiums due us and to process claims for health care services you receive.
- ***For Treatment***. We may disclose health information to your doctors 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 and to help manage your health care coverage. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- ***To Plan Sponsors***. If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.
- ***For Appointment Reminders***. We may use health information to contact you for 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:

- ***To Persons Involved With Your Care***. We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- ***For Public Health Activities*** such as reporting disease outbreaks.
- ***For Reporting Victims of Abuse, Neglect or Domestic Violence*** to government authorities, including a social service or protective service agency.
- ***For Health Oversight Activities*** such as 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*** such as providing limited information to locate a missing person.
- ***To Avoid a Serious Threat to Health or Safety*** by, for example, disclosing information to public health agencies.
- ***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*** including disclosures required by state workers compensation laws of job-related injuries.

- ***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.

If none of the above reasons apply, **then we must get your written authorization to use or disclose your health information**. If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, refer to "Exercising Your Rights" on page 4 of this notice.

Highly Confidential Information

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;
- Sexually transmitted diseases and reproductive health information; and
- Child or adult abuse or neglect, including sexual assault.

Attached to this notice is a *Summary of State Laws on Use and Disclosure of Certain Types of Medical Information*.

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 may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with its 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).
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.

- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. 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 disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that 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 may obtain a copy of this notice at our website, **www.uhcspecialtybenefits.com**

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the phone number on your ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

United Healthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

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.

Financial Information Privacy Notice

We (including our affiliates listed at the bottom of this page)* are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We 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 and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your personal financial information.

**For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities on the first page of the Notice of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group, Inc.; ACN Group IPA of New York, Inc.; Alliance Recovery Services, LLC; AmeriChoice Health Services, Inc.; Behavioral Health Administrators; Continental Plan Services, Inc.; Coordinated Vision Care, Inc.; DBP-KAI, Inc.; Disability Consulting Group, LLC; DCG Resource Options, LLC; Definity Health Corporation; Definity Health of New York, Inc.; Dental Benefit Providers, Inc.; Dental Insurance Company of America; Exante Bank, Inc.; Fidelity Benefit Administrators, Inc.; HealthAllies, Inc.; IBA Self Funded Group, Inc.; Illinois Pacific Dental, Inc.; Lifemark Corporation; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; Midwest Security Administrators, Inc.; Midwest Security Care, Inc.; National Benefit Resources, Inc.; NPD Dental Services; NPD Insurance Company, Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Pacific Dental Benefits; PacifiCare Behavioral Health NY IPA, Inc.; PacifiCare Health Plan Administrators, Inc.; ProcessWorks, Inc.; Spectera of New York, IPA, Inc.; Uniprise, Inc.; United Behavioral Health of New York, I.P.A., Inc.; UnitedHealth Advisors, LLC; United HealthCare Services, Inc.; UnitedHealthcare Services Company of the River Valley, Inc.; United HealthCare Service LLC; United Medical Resources, Inc.*

Summary of State Laws on Use and Disclosure of Certain Types of Medical Information

This information is intended to provide an overview of state laws that are more stringent than the federal *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules* with respect to the use or disclosure of protected health information in the categories listed below.

Sexually Transmitted Diseases and Reproductive Health	
Disclosure of sexually transmitted diseases and reproductive health related information may be: (1) limited to specified circumstances; and/or (2) restricted by the patient.	HI, MS, NM, NY, NC, OK, WA, VA
Disclosure of sexually transmitted diseases and reproductive health information must be accompanied by a written statement meeting certain requirements.	NM
There are specific requirements that must be followed when an insurer uses or requests sexually transmitted disease tests or reproductive health information for insurance or underwriting purposes.	MS
Alcohol and Drug Abuse	
Disclosure of alcohol and drug abuse information may be: (1) limited to specified circumstances; (2) restricted by the patient; and/or (3) prohibited under certain circumstances.	GA, HI, KY, MA, NH, OK, VA, WA, WI
A specific written statement must accompany any alcohol and drug abuse information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests drug and alcohol tests or information for insurance or underwriting purposes.	KY, VA
Genetic Information	
An authorization is required for each disclosure of genetic information.	CA, HI, KY, LA, RI, TN
Genetic information may be disclosed only under specific circumstances.	AZ, CO, FL, GA, HI, IL, MD, MA, MO, NV, NH, NJ, NM, NY, OR, TX, VT
Restrictions apply to (1) the use; and/or (2) the retention of genetic information.	CO, GA, IL, NV, NJ, NM, OR, VT, WY
Specific requirements must be followed when an insurer uses or requests a genetic test for insurance or underwriting purposes.	FL, IL, IN, LA, NV, WY

HIV/AIDS	
Disclosure of HIV/AIDS related information may only be: (1) limited to specific circumstances; and/or (2) restricted by the patient.	AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KY, ME, MA, MI, NH, NJ, NM, NY, NC, OH, OK, OR, PA, TX, UT, VT, VA, WA, WV, WI
A specific written statement must accompany any HIV/AIDS related information.	AZ, CT, KY, NM, OR, PA, WV
Certain restrictions apply to the retention of HIV/AIDS related information.	MA, NH
Specific requirements must be followed when an insurer uses or requests an HIV/AIDS test for insurance or underwriting purposes.	AR, DE, FL, IA, MA, NH, PA, UT, VA, VT, WA, WV
Improper disclosure may be subject to penalties.	DE
Disclosure to the individual and/or designated physician may be required.	MA, NH
Mental Health	
Disclosure of mental health information may be: (1) limited to specific circumstances; (2) restricted by the patient; and/or (3) prohibited or prevented under certain circumstances.	AL, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, IA, KY, ME, MA, MD, MI, MN, NM, NY, OK, PA, TN, TX, VT, VA, WA, WV, WI
A specific written statement must accompany any mental health information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests mental health information for insurance or underwriting purposes.	IA, KY, ME, MA, NM, TN, VA
Child or Adult Abuse	
Abuse related information may only be disclosed under specific circumstances.	AL, LA, NM, TN, UT, VA, WI

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your enrolling group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the policy 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 for adoption with the subscriber during a period of continuation coverage under federal law.
- A subscriber's former spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

A. Termination of the subscriber from employment with the enrolling group, for any reason other than gross misconduct.

B. Reduction in the subscriber's hours of employment.

With respect to a subscriber's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

A. Termination of the subscriber from employment with the enrolling group, for any reason other than the subscriber's gross misconduct.

B. Reduction in the subscriber's hours of employment.

C. Death of the subscriber.

D. Divorce or legal separation of the subscriber.

E. Loss of eligibility by an enrolled dependent who is a child.

F. Entitlement of the subscriber to Medicare benefits.

G. The enrolling group filing for bankruptcy, under Title 11, United States Code. 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.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

Notification Requirements for Qualifying Event

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator within 60 days of the latest of the date of the following events:

- The subscriber's divorce or legal separation, or an enrolled dependent's loss of eligibility as an enrolled dependent.
- The date the Qualified Beneficiary would lose coverage under the policy.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The subscriber or other Qualified Beneficiary must also notify the enrolling group's plan administrator when a second qualifying event occurs, which may extend continuation coverage.

If the subscriber or other Qualified Beneficiary fails to notify the enrolling group's plan administrator of these events within the 60 day period, the plan administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a subscriber is continuing coverage under federal law, the subscriber must notify the enrolling group's plan administrator within 60 days of the birth or adoption of a child.

Notification Requirements for Disability Determination or Change in Disability Status

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator as described under "Terminating Events for Continuation Coverage under Federal Law (COBRA)," subsection A. below.

The notice requirements will be satisfied by providing written notice to the enrolling group's plan administrator. The contents of the notice must be such that the plan administrator is able to determine the covered employee and Qualified Beneficiary or beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the subscriber or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the enrolling group's plan administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage 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 plan administrator.

The Qualified Beneficiary's initial premium due to the plan administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If you qualify or may qualify for assistance under the Trade Act of 1974, contact the enrolling group for additional information. You must contact the enrolling group promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that plan coverage was lost but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

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

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the subscriber's employment was terminated or hours were reduced (i.e., qualifying event A.).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

   - Notice of such disability must be provided within the latest of 60 days after:
   - the determination of the disability; or
   - the date of the qualifying event; or
   - the date the Qualified Beneficiary would lose coverage under the policy; and
   - in no event later than the end of the first eighteen months.
   - The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.
   - If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

   Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that 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, or loss of eligibility by an enrolled dependent who is a child (i.e. qualifying events C., D., or E.).

C. With respect to Qualified Beneficiaries, and to the extent that the subscriber was entitled to Medicare prior to the qualifying event:

   - Eighteen months from the date of the subscriber's Medicare entitlement; or
   - Thirty-six months from the date of the subscriber's Medicare entitlement, if a second qualifying event (that was due to either the subscriber's termination of employment or the subscriber's work hours being reduced) occurs prior to the expiration of the eighteen months.

D. With respect to Qualified Beneficiaries, and to the extent that the subscriber became entitled to Medicare subsequent to the qualifying event:

- Thirty-six months from the date of the subscriber's termination from employment or work hours being reduced (first qualifying event) if:
- The subscriber's Medicare entitlement occurs within the eighteen month continuation period; and
- If, absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

E. The date coverage terminates under the policy for failure to make timely payment of the premium.

F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the enrolling group filed for bankruptcy, (i.e. qualifying event G.). If the Qualified Beneficiary was entitled to continuation because the enrolling group filed for bankruptcy, (i.e. qualifying event G.) and the retired subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the subscriber's death.

H. The date the entire policy ends.

I. The date coverage would otherwise terminate under the policy.

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

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

Receive Information About Your Plan and Benefits

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

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

You are entitled to receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *COBRA* continuation rights. Review this *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal

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

Assistance with Your Questions

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