UnitedHealthcare Direct Compensation Dental HMO Dental

Dental Benefit Providers of California, Inc.

Combined Dental Evidence of Coverage and Disclosure Form

For

Peralta Community College District

Dental Plan Number: D1065

Enrolling Group Number: 729309

Effective Date: July 1, 2022

Dental Benefit Providers of California, Inc.

3120 W. Lake Center Drive

Santa Ana, California 92704

1-800-999-3367

Combined Dental Evidence of Coverage and Disclosure Form

What Is the Evidence of Coverage?

This *Evidence of Coverage ("EOC")* is part of the Contract that is a legal document between Dental Benefit Providers of California, Inc. and the Group. The *EOC* describes Covered Dental Care Services, subject to the terms, conditions, exclusions and limitations of the Contract. We issue the Contract based on the Group's *Application* and payment of the required Contract Charges.

In addition to this *EOC,* the Contract includes:

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

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

Can This Evidence of Coverage Change?

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

Other Information You Should Have

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

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

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

We are delivering the Contract in California. The Contract is subject to the laws of the state of California and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, California law governs the Contract.

Introduction to Your Evidence of Coverage

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

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to Dental Benefit Providers of California, Inc. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

How Do You Use This Document?

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

Review the Benefit limitations of this *EOC* by reading the attached *Schedule of Covered Dental Care Services* along with *Section 1: Covered Dental Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 7: General Legal Provisions* to understand how this *EOC* and your Benefits work. Call us if you have questions about the limits of the coverage available to you. A copy of the plan contract will be furnished upon request and is available at Dental Benefit Providers of California, Inc., and your employer group's personnel office.

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

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

How Do You Contact Us?

Call us at 1-800-999-3367. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Enrollment and Required Contributions

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

- Your enrollment must be in accordance with the requirements of the Contract issued to your Group, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 8: Defined Terms*.

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

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

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

Decide What Services You Should Receive

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

Choose Your Dental Provider

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

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

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at 8002283384 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

Pay Your Share

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

Pay the Cost of Excluded Services

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

File Claims with Complete and Accurate Information

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

Our Responsibilities

Determine Benefits

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

As part of our routine operations we apply the terms of our policy and certificate forms for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures, and processes.

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

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

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

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

- As shown in the most recent edition of the *Current Dental Terminology (publication of the American Dental Association)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. We compensate providers using direct reimbursement, discounted fee for service, fee for service and capitation. Network Dental Providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network Dental Providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Dental Provider or provider by contacting us at www.myuhc.com or by calling us at 1-800-999-3367.

Evidence of Coverage Table of Contents

Section 1: Covered Dental Care Services

When Are Benefits Available for Covered Dental Care Services?

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

- The dental care service, including supplies or Pharmaceutical Products, is only a Covered Dental Care Service if it is Necessary. (See definitions of Necessary and Covered Dental Care Service in *Section 8: Defined Terms*.)
- You receive Covered Dental Care Services while the Contract is in effect.
- You receive Covered Dental Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Dental Care Services is a Covered Person and meets all eligibility requirements specified in the Contract.

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

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

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

Timely Access to Care

Covered health care services are provided and arranged in a timely manner appropriate for the nature of the Covered Person's condition consistent with good professional practice. Provider Networks, policies, procedures and quality assurance monitoring systems and processes are established and maintained to ensure compliance with clinical appropriateness standards.

All network and provider processes necessary to obtain covered dental care services, including but not limited to prior authorization processes, are completed in a manner that assures covered dental care services are provided to Covered Persons in a timely manner appropriate for the Covered Person's condition.

When it is necessary for a provider or a Covered Person to reschedule an appointment, the appointment will be promptly rescheduled in a manner that is:

i) Appropriate for the Covered Person's health care needs,

ii) Ensures continuity of care consistent with good professional practices; and

iii) Meets the California standards regarding the accessibility of provider services in a timely manner.

Interpreter services are coordinated with scheduled appointments for health care services in a manner that ensures interpreter services are provided at the time of the appointment, consistent with California standards without imposing an undue delay on the scheduling of the appointment.

Contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following requirements:

(A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;

(B) Non-urgent appointments shall be offered within 36 business days of the request for appointment, except as provided in (C) below; and

(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.

Telephone triage or screening services are provided in a timely manner appropriate for the insured's condition. During normal business hours, the waiting time for a Covered Person to speak by telephone with a customer service representative knowledgeable and competent regarding the Covered Person's questions and concerns will not exceed ten minutes.

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

1. Classes of Dental Benefits

Below are descriptions of various dental care services. **Please check your Schedule of Covered Dental Care Services to verify what dental benefits are available to you**.

Class I - Dental Benefits

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

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

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

Class II - Dental Benefits

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

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

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

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

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

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

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

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

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

Class III - Dental Benefits

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

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

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

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

Class IV - Dental Benefits

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

2. Virtual Visits

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

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

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

Benefits are available only when services are delivered through a Participating Dentist. You can find a Participating Dentist by contacting us at www.myuhc.com or by calling us at 1-800-999-3367.

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

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

3. Prenatal Dental Care

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

Section 2: Exclusions and Limitations

We Do Not Pay Benefits for Exclusions

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

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

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

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Dental Care Service categories described in *Section 1: Covered Dental Care Services*, those limits are stated in the corresponding Covered Dental Care Service category in the *Schedule of Covered Dental Care Services*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

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

Exclusions

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

1. Dental Care Services that are not Necessary.
2. Hospitalization or other facility charges. Costs for non-Dental Care Services related to the provision of Dental Care Services in hospitals, extended care facilities, or Subscriber's home. When deemed Necessary by the Network Dental Provider, the Subscriber's Physician and authorized by us, Covered Dental Care Services that are delivered in an inpatient or outpatient hospital setting are Covered as indicated in the *Schedule of Covered Dental Care Services*.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting. This will not apply to Covered Emergency Dental Care Services.
7. Procedures that are considered to be Experimental, Investigational or Unproven. Any treatment, device or pharmacological regimen that is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be an Experimental, Investigational or Unproven Service.
8. Any implant procedures performed which are not listed as covered implant procedures in the *Schedule of Covered Dental Care Services*.

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

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

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

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

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

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

15. Expenses for Dental Procedures begun prior to you becoming enrolled under the Contract.

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

17. 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.

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

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

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

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

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

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

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

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

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

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

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

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

30. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday. Pediatric specialty services will not be excluded beyond the enrollee's 8th birthday if the enrollee receives prior authorization.

31. Consultations for non-Covered services.

32. A service started but not completed prior to the Covered Person's eligibility to receive benefits under 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. Orthodontics are considered started at the time of initial banding. Dentures are considered started when the impressions are taken.

33. A service started (as defined above) by an out-of-Network Dental Provider. This will not apply to Covered Emergency Dental Care Services.

34. 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.

35. 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.

36. Relative analgesia (N2O2- nitrous oxide).

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

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

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 Co-payments 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.

1. The following are not Covered orthodontic Benefits:

    - Treatment in progress prior to the effective date of this Coverage.
    - 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. Covered Charges will include changes in treatment necessitated by an accident if deemed medically necessary.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

2. If a treatment plan is for less than 24 months, then a prorated portion of the full Co-payment shall apply.

3. 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.

4. 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. The fee will be waived if the treatment program is completed.

5. Orthodontic Treatment that extends beyond 24 months will be subject to an office visit charge, which will be the members responsibility. The charge for each additional month will not exceed $125.00 per month.

Section 3: When Coverage Begins

How Do You Enroll?

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

Who Is Eligible for Coverage?

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

Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 8: Defined Terms*.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

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

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

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

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

Open Enrollment Period

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

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

New Eligible Persons

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

Adding New Dependents

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

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

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

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis. A plan can end for cause when a group or member commits an act that violates state or federal law (such as insurance fraud)

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

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

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

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

- The Eligible Person previously declined coverage under the Contract, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing dental coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including legal separation, divorce or death).

- The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
- In the case of COBRA continuation coverage, the coverage ended.
- The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
- The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

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

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

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

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

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Contract Ends**

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

  We have the right to terminate your coverage under this Health Plan in the following situations:

  - For Nonpayment of Premiums. Your coverage may be terminated if the Employer Group did not pay the required Premiums.
  - We will mail your employer a Notice of Start of Grace Period, no later than five (5) business days after the last day of paid coverage. The premium amount must be paid not later than 30 days from the date of the Notice.
  - If payment is not received from your employer within 30 days of the date the Notice of Grace Period, coverage will be cancelled and we mail you a Notice of End of Coverage.

- **The Subscriber No Longer Lives or Works within the Service Area, after 30 days written notice**

  Your coverage ends on the last day of the calendar month in which the Subscriber no longer lives or works in the Service Area after we send 30 days written notice. The Subscriber or the Group must notify us if the Subscriber moves from the Service Area.

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the month you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 8: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

If you believe your policy or coverage has been or will be wrongly canceled, rescinded or not renewed, please refer **to Section 6; Grievances Involving the Cancellation, Rescission or Non-Renewal of Health Plan,** to learn how to request a review by the Department of Managed Care (DMHC) Director.

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 30 days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 180 days following the date of the notice. The notice will contain information on how to appeal the decision.

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

Coverage for a Disabled Dependent Child

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

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

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

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

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

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

Extended Coverage

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

- Benefits for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared.
- Benefits for any other dental prosthesis is incurred on the date the first master impression is made.

- Benefits for root canal treatment is incurred on the date the pulp chamber is opened.
- Benefits for orthodontic treatment is incurred on the date the active orthodontic appliance is first placed.

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

Continuation of Covered Services When Provider Terminates

At your request we will arrange for the completion of covered services by a terminated Participating Dentist or a newly Covered Person's Non-participating Dentist, unless reasonable and medically appropriate arrangements for assumption of such services by another provider are made, if you are undergoing a course of treatment for an Acute Condition or Serious Chronic Condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the plan in consultation with you and the terminated provider or nonparticipating provider, and consistent with good professional practice. The completion of covered services shall not exceed 12 months from the contract termination date or 12 months for the effective date of coverage for a newly covered enrollee.

Completion of covered services shall be provided for surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date, or within 180 days of the effective date of coverage for a newly covered enrollee.

We may require the terminated Participating Dentist, whose services are continued beyond the contract termination date pursuant to this section, to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the Participating Dentist prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated Participating Dentist does not agree to comply or does not comply with these contractual terms and conditions, we are not required to continue the provider's services beyond the contract termination.

Unless otherwise agreed upon between the terminated Participating Dentist and us, or between the terminated Participating Dentist and the provider group, the agreement shall be construed to require a rate and method of payment to the terminated Participating Dentist, for the services rendered pursuant to this section, that are the same as the rate and method of payment for the same services while under contract with us and at the time of termination. The Participating Dentist shall accept the reimbursement as payment in full and shall not bill you for any amount in excess of the reimbursement rate, with the exception of Copayments and deductibles. The payment of Copayments, deductibles, or other cost-sharing components by you during the period of completion of covered services with a terminated Participating Dentist shall be the same Copayments, deductibles, or other cost-sharing components that would be paid by you when receiving care from a Participating Dentist currently contracting with the insurer.

Renewal and Reinstatement (Renewal Provisions)

The Contract renews automatically, on a yearly basis, subject to all terms of the Contract. The Company or your Employer may change your health plan benefits and Premium at renewal. If the Contract is terminated by the Company, reinstatement is subject to all terms and conditions of the Contract. The Employer Group is required to notify you of any such amendment or modification.

Reinstatement of the Contract After Termination

If your Coverage is terminated for nonpayment, the Company shall reinstate the Coverage as though it had never been terminated if such payment is received on or before the due date of the succeeding prepaid or periodic payment. In the event of nonpayment of Premium, you or the Employer Group will be given at least 30 days from the last date of paid coverage to pay the Premium. Termination for nonpayment of Premiums is prospective from the 31st day after the Notice of Grace Period is sent.

The Company shall not reinstate the Coverage if one of the following exceptions exist:

1. In the notice of termination, the Company notifies you that if payment is not received within the 30 days of the Notice of Grace Period, a new application is required and the conditions under which a new Contract will be issued or the original contract reinstated; or

2. If such payment is received more than the 30 day grace period after issuance of the Notice of Grace Period, the plan refunds such payment within 20 business days; or

3. If such payment is received more than the 30 day grace period after issuance of the Notice of Grace Period, the plan issues to you, within 20 business days of receipt of such payment, a new Contract accompanied by written notice stating clearly those respects in which the new Contract differs from the cancelled Contract in benefits, coverage or otherwise.

You remain responsible for all Copays, deductibles and other cost-sharing during the grace period.

Continuation of Coverage

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

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

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

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

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

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

Continuation Coverage under State Law (Cal-COBRA)

You should call your Enrolling Group or us if you have questions about your right to continue coverage under state law.

In order to be eligible for continuation coverage under state law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any individual who was covered under the Policy on the day before a qualifying event.

Qualifying Events for Continuation Coverage under State Law (Cal-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.

A. Termination of employment or reduction in hours of the Subscriber from employment with the Enrolling Group, for any reason other than gross misconduct; 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. For Enrolled Dependents only, the entitlement of the Subscriber to Medicare benefits.

The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

Exemptions to Coverage under State Law (Cal-COBRA)

The continuation requirements of this section do not apply to the following:

- Individuals who are or who become entitled to Medicare benefits.
- Individuals who have other hospital, surgical or medical coverage, or who are or become covered under another group health plan.
- Individuals who are covered, become covered, or are eligible for federal COBRA coverage.
- Individuals who are covered, become covered, or are eligible for coverage pursuant to Chapter 6A of the Public Health Code.
- Qualified Beneficiaries who fail to meet the requirements of this section regarding notification of a qualifying event or election of continuation coverage.
- Qualified Beneficiaries who fail to submit correct Premium for continuation coverage.

Notification Requirements and Election Period for Continuation Coverage under State Law (Cal-COBRA)

The Subscriber or other Qualified Beneficiary must notify us within 60 days of the Subscriber's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent, including loss of eligibility of an Enrolled Dependent due to the Subscriber's entitlement to Medicare. If the Subscriber or other Qualified Beneficiary fails to notify us of these events within the 60 day period, we are not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under state law, the Subscriber must notify us within 30 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 us. The Qualified Beneficiary's request must be in writing and delivered to us by first-class mail, or other reliable means of delivery, including personal delivery, express mail or private courier company within the 60-day period following the later of: (1) the date that the insured's coverage under the group health plan terminated or will terminate by reason of a qualifying event, or (2) the date the insured was sent notice of the ability to continue coverage under the group health benefit plan.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial Premium due to us must be paid on or before the 45th day after electing continuation. The amount of the initial Premium must be equal to the full amount billed by us. Failure to submit the correct initial Premium

amount billed within the 45-day period will disqualify the Qualified Beneficiary from receiving continuation coverage pursuant to this section.

If you were covered under a prior carrier and your former employer replaces your prior coverage with us, you may continue the remaining balance of your unused coverage with us, but only if you enroll with us and pay the required Premium to us within 30 days of receiving notice of the termination from the prior carrier.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Terminating Events for Continuation Coverage under State Law (Cal-COBRA)

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

- Thirty-six months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because of the Subscriber's termination of employment or reduction in hours. (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 must provide notice of such disability to us within 60 days of the date of the determination letter and prior to the end of the original 36 month continuation coverage period. If the Qualified Beneficiary is no longer disabled, then coverage will be terminated the later of the original 36 month continuation coverage period, or the month that begins more than 31 days after the date of the final determination under the Social Security Act that the Qualified Beneficiary is no longer disabled. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination.
- The date coverage terminates under the Policy for failure to make timely payment of the Premium.
- 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, or loss of eligibility due to the Subscriber's entitlement to Medicare benefits (i.e. qualifying events B, C, D, or E).
- The date, after electing continuation coverage, that the Qualified Beneficiary has other hospital, medical, or surgical coverage, or is or becomes covered under another group health plan.
- The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare.
- The date the entire Policy ends.
- The date coverage would otherwise terminate under the Policy as described in this section under the heading *Events Ending Your Coverage*.

Section 5: How to File a Claim

How Are Covered Dental Care Services from Network Providers Paid?

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

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

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

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that dental care service will be denied or reduced, as determined by us. This time limit does not apply if you are legally incapacitated.

Required Information

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

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

The above information should be filed with us at Claims Department, P.O. Box 30978, Salt Lake City, UT 84130 or by fax to 248-733-6060. If you would like to use a claim form, you may access a form on the Internet at www.myuhc.com or call us at 1-800-999-3367 and a claim form will be provided to you.

Payment of Benefits

You may not assign your Benefits under the Contract or any cause of action related to your Benefits under the Contract to an out-of-Network Dental Provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to the Subscriber for reimbursement to an out-of-

Network provider. We may, as we determine, pay an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network Dental Provider, we have the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

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

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

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

Section 6: Questions, Complaints and Appeals

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

What if You Have a Question?

Contact Customer Service at 1-800-999-3367. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Contact Customer Service at 1-800-999-3367. Representatives are available to take your call during regular business hours, Monday through Friday.

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

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

How Do You Appeal a Claim Decision?

Grievance Procedures

If you or one of your eligible dependents has a grievance with us or your dentist, you may orally submit such grievance by calling our Customer Service Department at (877) 813-4259 or 1-877-735-2929 (TDHI) or 711 (TTY/TDD). We will permit grievances which are filed within 180 days of the occurrence or incident that is the subject of the grievance.

You may also submit a completed written grievance form (available by calling the Customer Service number), and it will be promptly provided. If you prefer, you may also submit a detailed summary of your grievance to:

Dental Benefit Providers of California, Inc.

Dental Appeals

P.O. Box 30569

Salt Lake City, UT 84130-0569

Fax: 714-364-6266

Please be sure to include your name (patient's name, if different), Member Identification Number, facility (or Selected General Dentist) name and number on all written correspondence.

We agree, subject to our Complaint Procedure, to duly investigate and endeavor to resolve any and all complaints received from Members regarding the plan. We will confirm receipt of your complaint in writing within five (5) calendar days of receipt. We will resolve the complaint and communicate the resolution in writing within thirty (30) calendar days.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you can telephone your health plan at **1-(877) 813-4259** and use your health plan's grievance process or you can contact the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Website **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

A guardian may file a grievance on behalf of a minor or someone who is incompetent or incapacitated.

There will be no discrimination against you, including cancellation of your insurance, on the grounds that you filed a grievance.

Grievances Involving the Cancellation, Rescission or Non-Renewal of Health Plan

If you believe that your dental plan enrollment or subscription has been, or will be improperly rescinded, canceled, or not renewed, you have the right to file a complaint. A complaint is also called a grievance or an appeal.

You may file your complaint with Dental Benefit Providers of California, Inc

You can file a complaint by calling our Customer Service department at Customer Service Department at (877) 813-4259 or 1-877-735-2929 (TDHI) or 711 (TTY/TDD) or you may also submit a detailed summary of your grievance to:

Dental Benefit Providers of California, Inc.

Dental Appeals

P.O. Box 30569

Salt Lake City, UT 84130-0569

Fax: 714-364-6266

- You should file your complaint as soon as possible after you receive notice that your dental plan enrollment or subscription will be rescinded, canceled or not renewed.
- If your problem is urgent, Dental Benefit Providers of California, Inc, must give you a decision within 3 days. Your problem is urgent if there is a serious threat to your health that must be resolved quickly.
- If your problem is not urgent, Dental Benefit Providers of California, Inc, must give you a decision within 30 days.

Or you may take your complaint to the California Department of Managed Health Care (DMHC)

The DMHC oversees HMOs and other health plans in California and protects the rights of HMO members.

If you need help with this process, contact the DMHC Help Center at the toll-free telephone number (1-888-466-2219 TDD: 1-877-688-9891 FAX: 1-916-255-5241), or submit an inquiry in writing to the DMHC, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725 or through the website: http://www.HEALTHHELP.ca.gov.

Post-service Claims

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

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests prior to receiving dental care.

How to Request an Appeal

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

Your request for an appeal should include:

- The patient's name and Contract number.
- The date(s) of dental care service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a dental care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask dental experts to take part in the appeal process. You consent to this referral and the sharing of needed dental claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

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

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.

- For appeals of post-service claims as defined above, the appeal will take place and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

Please note that our decision is based only on whether or not Benefits are available under the Contract for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Dental Provider should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Dental Provider to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Independent External Review Program

If we deny Benefits because it was determined that the treatment is not Necessary or was an Experimental or Investigational Service, you may request an Independent External Review (IER) from the California Department of Managed Health Care (CDMHC) at no cost to you.

First Steps: Appeal the denial using our internal appeals/grievance process.

Find out the reason for the denial and review the Contract language supporting the denial.

Submit all necessary support for treatment, with dental provider(s) statements and dental records.

Provide research showing the treatment requested is accepted and appropriate, if possible.

IER Deadlines: If we uphold our decision or delay responding to your appeal/grievance, then you may file a Request for Assistance or an IER request with CDMHC. This request must be made within 6 months of our upholding the decision on appeal.

Getting Independent External Review: In this process, expert independent dental professional review the decisions made by us and often decide in favor of the Covered Person getting the dental treatment requested.

An IER can be requested if our decision involves:

- Dental claims that have been denied, modified, or delayed by us because a Covered Dental Service or treatment was not considered Necessary;
- Dental claims that have been denied for urgent or emergency services that a provider recommended was Necessary;
- Dental claims that have been denied as being Experimental or Investigational Services

6 Easy Steps to IMR:

1. Notify CDMHC to request an IER and fill out an application.
2. Agree and provide written consent
3. The CDMHC determines if the request is eligible for IER.
4. The IER Organization will have 30 days to review once all information is gathered-unless the request involves an imminent and serious threat to health, which can be expedited and a decision rendered in 3 days.
5. The IMR organization will send the decision to the Covered Person, Dental Benefit Providers of California, and the California Department of Managed Health Care.
6. The California Department of Managed Health Care will adopt the recommendation of the IER organization and promptly notify the Covered Person and us. The decision is binding on Dental Benefit Providers of California.

Reviewing Coverage Denials: If we deny treatment as not a Covered Dental Service, or if CDMHC finds that the issue does not involve a disputed health care service, CDMHC will review our decision for correctness.

Contact us at the telephone number shown on your ID card for more information on the independent external review program.

Contact the California Department of Managed Health Care:

You may contact the California Department of Managed Health Care for information on the independent external review program by calling: 1-888-466-2219

You may also write the California Department of Managed Healthcare at:

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Section 7: General Legal Provisions

What Is Your Relationship with Us?

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

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

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

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

What Is Our Relationship with Providers and Groups?

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Dental Care Services to Covered Persons.

We do not provide dental care services or supplies, or practice medicine. We arrange for dental providers to participate in a Network and we pay Benefits. Network Dental Providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. We are not responsible for any act or omission of any dental provider.

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

The Group is solely responsible for all of the following:

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

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

What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

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

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

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

Notice

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

Statements by Group or Subscriber

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

Do We Pay Incentives to Providers?

We pay Network providers through various types of contractual arrangements.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change.

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting. In some instances, these programs may be offered in combination with a non-Dental Benefit Providers, Inc. entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Dental Provider. Contact us at www.myuhc.com or contact us at 1-800-999-3367 if you have any questions.

From time to time we may offer or provide insureds/enrollees with Dental Benefit Providers, Inc. with dental or oral health goods and/or services otherwise not covered under the Contract. In addition, we may arrange for third party dental or oral health providers, to provide discounted goods and services to insureds/enrollees of Dental Benefit Providers, Inc. While we have arranged these goods or services and/or third party provider discounts, the third party service providers are liable to the

applicants/insureds/enrollees for the provision of such goods and/or services. We are not responsible for the provision of such goods and/or services nor are we liable for the failure of the provision of the same. Further, we are not liable to the insureds/enrollees for the negligent provision of such goods and/or services by third party service providers.

Who Determines Benefits and Other Provisions under the Policy?

We will do all of the following:

- Pay Benefits according to the contract and subject to the other terms, conditions, limitations and exclusions set out in the Policy, including this Certificate, the Schedule of Benefits and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits. We may assign this authority to other persons or entities that provide services in regard to the administration of the Policy.

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

Who Provides Administrative Services?

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

Amendments to the Contract

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

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

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

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

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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

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

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

During and after the term of the Contract, we and our 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. Please refer to our *Notice of Privacy Practices*.

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

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

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

OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST

Do We Require Examination of Covered Persons?

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

Is Workers' Compensation Affected?

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

Subrogation and Reimbursement

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

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

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

The following persons and entities are considered third parties:

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

You agree as follows:

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

    Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to you or your representative not cooperating with us. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to

hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.

- Benefits paid by us may also be considered to be Benefits advanced.

- If you receive any payment from any party as a result of Sickness or Injury, and we allege some or all of those funds are due and owed to us, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.

- By participating in and accepting Benefits under the Contract, you agree that (i) any amounts recovered by you from any third party shall constitute Contract assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Contract (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by us to enforce its reimbursement rights.

- Our right to recovery will not be reduced due to your own negligence.

- By participating in and accepting Benefits from us, you agree to assign to us any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits we have paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize our right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

- We may, at our option, take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's name, which does not obligate us in any way to pay you part of any recovery we might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Contract is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse us, without our written approval.

- We have the final authority to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death our right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Contract, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Contract pertaining to reimbursement, we may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Contract. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- We and all Administrators administering the terms and conditions of the Contract's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of our final authority to (1) construe and enforce the terms of the Contract's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to us.

When Do We Receive Refunds of Overpayments?

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

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

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

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

rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

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

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

What Is the Entire Contract?

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

Section 8: Defined Terms

Acute Condition - a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

Allowed Amounts - for Covered Dental Care Services, incurred while the Contract is in effect, Allowed Amounts are determined by us as shown in the Schedule of Covered Dental Care Services. The Schedule of Covered Dental Care Services: (1) describes the Covered Dental Care Services and any applicable limitations to those services; (2) outline Co-payments that you are required to pay for each Covered Dental Care Service.

Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines. We develop these guidelines, as we determine, after review of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the Current Dental Terminology (CDT), a publication of the American Dental Association.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants pursuant to other appropriate source or determination that we accept.

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

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

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

COBRA - A health insurance plan which allows an employee who leaves a company to continue to be covered under the company's health plan, for a certain time period and under certain conditions. The name results from the fact that the program was created under the Consolidated Omnibus Reconciliation Act. The system is designed to prevent employees who are between jobs from experiencing a lapse in coverage.

Complaint - a dispute or objection regarding a provider, or the coverage, operations, or management policies of your plan.

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

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

- *Group Contract*.
- *Evidence of Coverage*.
- *Schedule of Covered Dental Care Services*.
- Group *Application*.
- Riders.

- Amendments.

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

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

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

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

- The Co-payment.
- The Allowed Amount.

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

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

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

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

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

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

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

The following conditions apply:

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

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

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Care Services through live audio and video technology.

Domestic Partner - A Registered Domestic Partner or an Unregistered Domestic Partner.

Domestic Partnership - A Registered Domestic Partnership or an Unregistered Domestic Partnership.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Contract.

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

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

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

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

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

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

Grievance - a request on the part of a member, a members representative, or a health care provider (with written member consent) to have a managed care plan reconsider a decision solely concerning the medical necessity and appropriateness of a health care service.

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

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

Material Violation - a significant misstatement on a form.

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

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

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

A. needed to meet your basic dental needs; and

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

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

D. consistent with the diagnosis of the condition; and

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

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

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

    2. safe with promising efficacy:

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

        b. in a clinically controlled research setting; and

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

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

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

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

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

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

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

Network Dental Provider - a Dental Provider 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 Care Services provided by the dental plan.

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

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

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

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

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

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

Registered Domestic Partner - A person of the opposite or same sex with whom the Subscriber has established a Registered Domestic Partnership, as defined by California Family Code, Section 297-297.5 and registered pursuant to California Family Code, Section 298.

Registered Domestic Partnership - A relationship between the Subscriber and one other person of the opposite or same sex, as defined by California Family Code, Section 297-297.5 and registered pursuant to California Family Code, Section 298.

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

Service Area - the geographic area we serve, which has been approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

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

Unregistered Domestic Partner - A person of the opposite or same sex with whom the Subscriber has established an Unregistered Domestic Partnership.

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

- They share the same permanent residence and the common necessities of life;

- They are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which they reside;
- Each is at least 18 years of age;
- Each is mentally competent to consent to contract;
- Neither is currently married to 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.

Urgent - Covered Services that are Necessary and cannot be delayed because of an unforeseen illness, injury or condition.

This combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

Schedule of Covered Dental Care Services

How do you Access Benefits?

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

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

Dental Care Services

Within the Service Area, you are entitled to receive all the Dental Care Services specified below and listed in Section 1: Covered Dental Care Services of the EOC. You must go to your Network Dental Provider for these services unless the dental plan has made prior special arrangements for you. If you do not use a Network Dental Provider and the dental plan has not approved the use of an out-of-Network Dental Provider you will not be Covered for any services received.

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

Coverage for Dental Care Services is subject to payment of the Premium required for Coverage under the Contract and payment of the Co-payment specified for any service shown below in this Schedule of Covered Dental Care Services and Section 1: Covered Dental Care Services of the EOC.

Network Dental Providers are responsible for submitting a request for payment directly to us; however, a Covered Person is responsible for any Co-payment at the time of service. If a Network Dental Provider bills a Covered Person, customer service should be called at 1-800-999-3367. A Covered Person does not need to submit claims for Network Dental Providers services or supplies.

Directory of Network Dental Providers

A Directory of Network Dental Providers will be made available. You may access the Directory of Network Dental Providers online at www.myuhc.com. You can also call customer service to determine which Dental Providers participate in the Network at 1-800-999-3367.

Changing Your Primary Care Dental Provider

You may transfer to another Primary Care Dental Provider (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 Dental Provider, you may contact us at 1-800-999-3367. 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 from your primary residence or primary workplace, you will be referred by us to an out-of-Network Dental Provider and instructed on reimbursement procedures for service costs in excess of plan Co-payments. For reimbursement procedure information, please contact us at 1-800-999-3367.

Changes in Dental Provider Participation In the Network

If: (a) the Dental Provider you selected is no longer a Network Dental Provider in the Network; or (b) if we take an administrative action which affects the Dental Provider's participation in the Network, we may have to enroll you with a different Network Dental Provider. If this occurs, you will have the opportunity to choose another Network Dental Provider 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 Network Dental Provider, 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 Network Dental Provider to complete the service. We will send you written notice when we are aware that a Network Dental Provider is no longer available to treat you.

When we change your Network Dental Provider: Under special circumstances we may require that a Subscriber change his or her Network Dental Provider. Generally, this happens at the request of the Network Dental Provider 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 Network Dental Provider, provided he or she is medically able and there is an alternative Network Dental Provider.

Emergency Dental Care Services

You should contact a Network Dental Provider, who will make arrangements for Emergency care. If you are unable to reach a Network Dental Provider in an Emergency during normal business hours, you must call our customer service department for instructions.

If you are unable to reach a Network Dental Provider in an Emergency after normal business hours, you may seek Emergency Dental Care Services from any licensed Dental Provider. Then, within 2 business days, you should call our customer service department to notify us of the Emergency claim.

The following definitions apply for this plan.

Specialist Dental Provider - A Network Dental Provider 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.

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

Usual and Customary fees must not exceed the fees that the Dental Provider would charge any similarly situated payor for the same services. In the event that a Dental Provider routinely waives Co-payments, Dental Care Services for which the Co-payments are waived are not considered to be Usual and Customary.

Usual and Customary fees are determined solely in accordance with our reimbursement policy guidelines. Our reimbursement policy guidelines are developed by us, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Dental Terminology,* a publication of the *American Dental Association*.

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination accepted by us.

Specialty Referrals

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

We compensate our Network Specialist Dental Provider the difference between their contracted fee and the Co-payment shown in the Schedule of Covered Dental Care Services. This is the only form of compensation that Network Specialists receive from us.

All Specialty Referral Services Must Be: (A) Pre-Authorized by us; and (B) Coordinated by a Covered Person's Network Dental Provider. Any Covered Person who elects specialist care without prior referral by his or her Network Dental Provider 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 Network Dental Provider must coordinate all Dental Care Services.
2. When the care of a Network Specialist Dental Provider is required, the Covered Person's Network Dental Provider must contact us and request authorization.
3. If the Network Dental Provider's request for specialist referral is approved, we will notify the Covered Person. He or she will be instructed to contact the Network Specialist Dental Provider to schedule an appointment.
4. If the Network Dental Provider's request for specialist referral is denied, the Network Dental Provider 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 Network Dental Provider may be asked to perform the service.
5. A Covered Person who receives authorized specialty services must pay all applicable Co-payments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dental Provider for treatment. The Network includes Network Specialist Dental Providers in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dental Provider in the Covered Person's Service Area, we will refer the Covered Person to an out-of-Network Specialist of our choice. Except for Emergency Dental Care 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.

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

Pediatric Specialty Services

During a Network Dental Provider visit, a Covered Person under age 8 may be unmanageable. In such case, the Covered Person may be referred to a Network pediatric Specialist Dental Provider for the current treatment plan only. Following completion of that authorized pediatric treatment plan, the Covered

Person must return to the Network Dental Provider for further services. Subsequent referrals to the Network pediatric Specialist Dental Provider, if any, must first be authorized by us. Any services performed by a pediatric Specialist Dental Provider after the Covered Person's 8th birthday will not be Covered unless preauthorization has been obtained. Listed Co-payments do not apply to pediatric specialty services. Instead, the parent or guardian is responsible for 49% of the pediatric Specialist Dental Provider's contracted rate.

Second Opinion Consultation

A Covered Person, or his or her treating Network Dental Provider, may submit a request for a second dental opinion to us by writing or calling us at 1-800-999-3367. 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 Network Dental Provider, 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 Dental Provider, the second dental opinion will be provided by a Specialist within the Network of the same or equivalent specialty.

The plan's benefit for a second opinion consultation is limited to $50.00. If a Network Dental Provider is the consultant, there is no cost to the Covered Person. If an out-of-Network Dental Provider is the consultant, the Covered Person must pay any portion of his or her fee over $50.00.

Additional Provisions

Age Limitations

Limitations based on age do not apply when the Covered Dental Service is Necessary.

Non-Covered and Alternative Procedures

More than one procedure may be appropriate for treating a dental condition. A Covered Person may choose an appropriate alternative procedure over the service the Network Dental Provider recommended. If the alternative procedure is Covered under the plan, the Covered Person pays the Co-payment for that procedure. If the alternative procedure is not Covered under the plan, the Network Dental Provider may charge his or her usual and customary charges for the non-Covered service.

Whenever there is more than one course of treatment available, a full disclosure of all the options must be given to the Covered Person before any treatment begins. When non-Covered services are part of a Covered Person's treatment plan, the Dental Provider should present the Covered Person with a treatment plan in writing before treatment begins, to assure that there is no confusion over what the Covered Person will be required to pay.

Multiple Crown/Bridge Unit Treatment Fee

A Covered Person's recommended treatment plan may include 6 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 Care Services. The maximum benefit within a 12-month period is for 6 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 Co-payment 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.

ADA	DESCRIPTION	MEMBER PAYS
DIAGNOSTIC SERVICES		
D0120	PERIODIC ORAL EVALUATION EST PT	$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	$0
D0145	ORAL EVAL PT<3 AND COUNSEL	$0
D0150	COMP ORAL EVALUATION - NEW/EST PT	$0
D0160	DTL&EXT ORAL EVAL - PROB FOCUS RPT	$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	$0
D0171	RE-EVALUATION – POST-OPERATIVE OFFICE VISIT	$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	$0
D0190	SCREENING OF A PATIENT	$0
D0191	ASSESMENT OF A PATIENT	$0
D0210	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES	$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$0
D0230	INTRAORL PERIAPICAL EA ADD RADIOGRAPHIC IMAGE	$0
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	$0
D0251	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	$0
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	$0
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	$0
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$0
D0290	POSTERIOR-ANTERIOR OR LATERAL SKULL AND FACIAL SURVEY RADIOGRAPHIC IMAGE	$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	$0
D0364	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$0
D0365	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$0
D0366	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$0
D0367	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS	$0
D0368	CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	$0
D0393	SIMULATION USING 3D IMAGES	$0
D0394	DIGITAL SUBTRACTION OF IMAGES	$0
D0395	FUSION OF TWO OR MORE 3D IMAGES	$0
D0414	LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	$0
D0415	COLLECT MICROORAGNISMS CULT & SENS	$0
D0416	VIRAL CULTURE	$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	$0
D0418	ANALYSIS OF SALIVA SAMPLE	$0
D0425	CARIES SUSCEPTIBILITY TESTS	$0
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	$0
D0460	PULP VITALITY TESTS	$0
D0470	DIAGNOSTIC CASTS	$0
D0472	ACCESS TISS-GROSS EXAM-PREP & REPRT	$0
D0473	ACCESS TISS-GROSS/MICRO-PREP/REPRT	$0
D0474	ACSS TISS GR&MIC SURG MARG PREP/RPT	$0
D0601	CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	$0
D0602	CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	$0

D0603	CARIES RISK ASSESSMENT AND DOCUMENTATION, HIGH	$0
PREVENTIVE SERVICES		
D1110	PROPHYLAXIS - ADULT	$0
D1120	PROPHYLAXIS - CHILD	$0
D1206	TOP FLUORIDE VARNISH	$0
D1208	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	$0
D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	$0
D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	$0
D1330	ORAL HYGIENE INSTRUCTIONS	$0
D1351	SEALANT - PER TOOTH	$0
D1352	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	$0
D1353	SEALANT REPAIR – PER TOOTH	$0
D1510	SPACE MAINTAINER - FIXED-UNILATERAL	$0
D1515	SPACE MAINTAINER - FIXED-BILATERAL	$0
D1520	SPACE MAINTAINER - REMOVABLE-UNI	$0
D1525	SPACE MAINTAINER - REMOVABLE-BIL	$0
D1550	RECEMENT OR RE-BOND SPACE MAINTAINER	$0
D1555	REMOVAL OF FIXED SPACE MAINTAINER	$0
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED – UNILATERAL	$0
RESTORATIVE SERVICES		
D2140	AMALGAM-ONE SURFACE PRIMARY/PERM	$0
D2150	AMALGAM-TWO SURFACES PRIMARY/PERM	$0
D2160	AMALGAM-3 SURFACES PRIMARY/PERM	$0
D2161	AMALGAM-FOUR/MORE SURF PRIM/PERM	$0
D2330	RESIN COMPOS - ONE SURFACE ANTERIOR	$0
D2331	RESIN COMPOS - 2 SURFACES ANTERIOR	$0
D2332	RESIN COMPOS - 3 SURFACES ANTERIOR	$0
D2335	RSN COMPOS-4/> SURF/W/INCISAL ANG	$0
D2390	RESIN COMPOS CROWN ANTERIOR	$0
D2391	RESIN COMPOS - 1 SURFACE POSTERIOR	$0
D2392	RESIN COMPOS - 2 SURFACES POSTERIOR	$0
D2393	RESIN COMPOS - 3 SURFACES POSTERIOR	$0
D2394	RESIN COMPOS - 4/MORE SURFACES POST	$0
D2510	INLAY - METALLIC - ONE SURFACE	$0
D2520	INLAY - METALLIC - TWO SURFACES	$0
D2530	INLAY - METALLIC - 3/MORE SURFACES	$0
D2542	ONLAY - METALLIC - TWO SURFACES	$0
D2543	ONLAY METALLIC THREE SURFACES	$0
D2544	ONLAY METALLIC FOUR OR MORE SURF	$0
D2610	INLAY - PORCELN/CERAMIC - 1 SURFACE	$0
D2620	INLAY - PORCELN/CERAMIC - 2 SURF	$0
D2630	INLAY - PORCELN/CERAM - 3/MORE SURF	$0
D2642	ONLAY - PORCELN/CERAMIC - 2 SURF	$0
D2643	ONLAY - PORCELN/CERAMIC - 3 SURF	$0
D2644	ONLAY - PORCELN/CERAM - 4/MORE SURF	$0
D2650	INLAY-RSN COMPOS COMPOS/RSN-1 SURF	$0
D2651	INLAY-RSN COMPOS COMPOS/RSN-2 SURF	$0
D2652	INLAY-RSN COMPOS COMPOS/RSN-3/>SURF	$0
D2662	ONLAY-RSN COMPOS COMPOS/RSN-2 SURF	$0
D2663	ONLAY-RSN COMPOS COMPOS/RSN-3 SURF	$0
D2664	ONLAY-RSN COMPOS COMPOS/RSN-4/>	$0
D2710	CROWN RESINBASED COMPOSITE INDIRECT	$0
D2712	CROWN 3/4 RESNBASED COMPOS INDIRECT	$0
D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	$0
D2721	CROWN - RESIN W/PREDOM BASE METAL	$0
D2722*	CROWN - RESIN WITH NOBLE METAL	$0
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$0

D2750*	CROWN - PORCELN FUSED HI NOBLE METL	$0
D2751	CROWN-PORCELN FUSD PREDOM BASE METL	$0
D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	$0
D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	$0
D2781	CROWN - 3/4 CAST PREDOM BASE METL	$0
D2782*	CROWN - 3/4 CAST NOBLE METAL	$0
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$0
D2790*	CROWN - FULL CAST HIGH NOBLE METAL	$0
D2791	CROWN - FULL CAST PREDOM BASE METL	$0
D2792*	CROWN - FULL CAST NOBLE METAL	$0
D2794*	CROWN TITANIUM	$0
D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	$0
D2915	RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFAB POST & CORE	$0
D2920	RECEMENT OR RE-BOND CROWN	$0
D2921	REATTACHMENT OF TOOTH FRAGMENT	$0
D2929	PREFABRICATED PORCELAIN CROWN- PRIMARY	$0
D2930	PRFABR STAINLESS STEEL CROWN-PRIM	$0
D2931	PRFABR STAINLESS STEEL CROWN-PERM	$0
D2932	PREFABRICATED RESIN CROWN	$0
D2933	PRFABR STNLSS STEEL CROWN RSN WNDOW	$0
D2934	PREFAB ESTHTC COATED STNLESS STEEL CROWN - PRIMARY	$0
D2940	SEDATIVE FILLING	$0
D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$0
D2950	CORE BUILDUP INCLUDING ANY PINS	$0
D2951	PIN RETN - PER TOOTH ADDITION REST	$0
D2952	POST & CORE ADD CROWN INDIRECT FAB	$0
D2953	EA ADD INDIRECT FAB POST SAME TOOTH	$0
D2954	PREFABR POST&CORE ADDITION CROWN	$0
D2955	POST REMOVAL	$0
D2957	EA ADD PREFABR POST - SAME TOOTH	$0
D2960	LABIAL VENEER (LAMINATE) - CHAIRSIDE	$0
D2961	LABIAL VENEER (RESIN LAMINATE) - LABORATORY	$0
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY	$0
D2971	ADD PROC NEW CROWN XST PART DENTURE	$0
D2975	COPING	$0
D2980	CROWN REPAIR	$0
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	$0
ENDODONTIC SERVICES		
D3110	PULP CAP - DIRECT	$0
D3120	PULP CAP - INDIRECT	$0
D3220	TX PULPOT-CORONL DENTNOCEMENTL JUNC	$0
D3221	PULPAL DEBRID PRIMARY&PERM TEETH	$0
D3222	PARTIAL PULPOTOMY	$0
D3230	PULPAL THERAPY - ANT PRIMARY TOOTH	$0
D3240	PULPAL THERAPY - POST PRIMARY TOOTH	$0
D3310	ANTERIOR	$0
D3320	BICUSPID	$0
D3330	MOLAR	$0
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	$0
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	$0
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	$0
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	$0
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	$0
D3348	RETX PREVIOUS RC THERAPY - MOLAR	$0
D3351	APEXIFICAT/RECALCIFICAT - INIT VST	$0
D3352	APEXIFICAT/RECALCIFICAT-INTERIM	$0
D3353	APEXIFICAT/RECALCIFICAT-FINAL VISIT	$0
D3355	PULPAL REGENERATION - INITIAL VISIT	$0

D3356	PULPAL REGENERATION -INTERIM MEDICAMENT REPLACEMENT	$0
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT	$0
D3410	APICOECTOMY SURG - ANT	$0
D3421	APICOECTOMY SURG-BICUSPID	$0
D3425	APICOECTOMY SURG - MOLAR	$0
D3426	APICOECTOMY SURGERY	$0
D3427	PERIRADICULAR SURGERY WITHOUT APICOECTOMY	$0
D3428	BONE GRAFT WITH PERIRADICULAR SURGERY - PER TOOTH	$0
D3429	BONE GRAFT WITH PERIRADICULAR SURGERY - EACH ADDITIONAL TOOTH	$0
D3430	RETROGRADE FILLING - PER ROOT	$0
D3431	BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION	$0
D3432	GUIDED TISSUE REGENERATION, RESORBABLE BARRIER, PER SITE	$0
D3450	ROOT AMPUTATION - PER ROOT	$0
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$1,950
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	$0
D3920	HEMISECTION NOT INCL RC THERAPY	$0
D3950	CANAL PREP&FIT PREFORMED DOWEL/POST	$0
PERIODONTIC SERVICES		
D4210	GINGIVECT/PLSTY 4/>CNTIG TEETH QUAD	$0
D4211	GINGIVECT/PLSTY 1-3CNTIG TEETH QUAD	$0
D4212	GINGIVECT/PLSTY WITH REST PROC/TOOTH	$0
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$0
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$0
D4245	APICALLY POSITIONED FLAP	$0
D4249	CLIN CROWN LEN - HARD TISSUE	$0
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$0
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$0
D4263	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT	$0
D4263	BONE REPLCMT GRAFT - 1 SITE QUAD	$0
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$0
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	$0
D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	$0
D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH	$0
D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD TOOTH	$0
D4320	PROVISIONAL SPLINTING - INTRACORONAL	$0
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	$0
D4341	PRDNTL SCAL&ROOT PLAN 4/>TEETH-QUAD	$0
D4342	PRDONTAL SCAL&ROOT PLAN 1-3 TEETH	$0
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	$0
D4355	FULL MOUTH DEBRID COMP EVAL&DX	$0
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$0
D4910	PERIODONTAL MAINTENANCE	$0
D4920	UNSCHEDULED DRESSING CHANGE	$0
D4921	GINGIVAL IRRIGATION - PER QUADRANT	$0
REMOVABLE PROSTHODONTIC SERVICES		
D5110	COMPLETE DENTURE - MAXILLARY	$0
D5120	COMPLETE DENTURE - MANDIBULAR	$0
D5130	IMMEDIATE DENTURE - MAXILLARY	$0
D5140	IMMEDIATE DENTURE - MANDIBULAR	$0
D5211	MAX PARTIAL DENTURE - RESIN BASE	$0
D5212	MAND PARTIAL DENTUR - RESIN BASE	$0
D5213	MAX PART DENTUR-CAST METL W/RSN	$0
D5214	MAND PART DENTUR- CAST METL W/RSN	$0

D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$0
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$0
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$0
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$0
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	$0
D5226	MANDIBULAR PART DENTURE FLEX BASE	$0
D5281	REMV UNI PART DENTUR-1 PC CAST METL	$0
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$0
D5411	ADJUST COMPLETE DENTUR - MANDIBULAR	$0
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$0
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$0
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	$0
D5512	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	$0
D5520	REPL MISS/BROKEN TEETH-CMPL DENTUR	$0
D5611	REPAIR RESIN PARTIAL DENTURE BASE - MANDIBULAR	$0
D5612	REPAIR RESIN PARTIAL DENTURE BASE - MAXILLARY	$0
D5621	REPAIR CAST PARTIAL FRAMEWORK - MANDIBULAR	$0
D5622	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	$0
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	$0
D5640	REPLACE BROKEN TEETH - PER TOOTH	$0
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	$0
D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	$0
D5670	REPL ALL TEETH&ACRYLC FRMEWRK MAX	$0
D5671	REPL ALL TEETH&ACRYLC FRMEWRK MAND	$0
D5710	REBASE COMPLETE MAXILLARY DENTURE	$0
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$0
D5720	REBASE MAXILLARY PARTIAL DENTURE	$0
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$0
D5730	RELINE CMPL MAXIL DENTURE CHAIRSIDE	$0
D5731	RELINE CMPL MAND DENTURE CHAIRSIDE	$0
D5740	RELINE MAXIL PART DENTURE CHAIRSIDE	$0
D5741	RELINE MAND PART DENTURE CHAIRSIDE	$0
D5750	RELINE CMPL MAXIL DENTURE LAB	$0
D5751	RELINE CMPL MAND DENTRUE LABORATORY	$0
D5760	RELINE MAXIL PART DENTURE LAB	$0
D5761	RELINE MAND PART DENTURE LABORATORY	$0
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	$0
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	$0
D5820	INTERIM PARTIAL DENTURE MAXILLARY	$0
D5821	INTERIM PARTIAL DENTURE MANDIBULAR	$0
D5850	TISSUE CONDITIONING MAXILLARY	$0
D5851	TISSUE CONDITIONING MANDIBULAR	$0
D5863	OVERDENTURE - COMPLETE MAXILLARY	$0
D5864	OVERDENTURE - COMPLETE MANDIBULAR	$0
D5865	OVERDENTURE - PARTIAL MAXILLARY	$0
D5866	OVERDENTURE - PARTIAL MANDIBULAR	$0
D5994	PERIODONTAL MEDICAMENT CARRIER WITH PERIPHERAL SEAL	$0

IMPLANT SERVICES

D6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$1,950
D6011	SECOND STAGE IMPLANT SURGERY	$1,950
D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	$1,950
D6052	SEMI-PRECISION ATTACHMENT ABUTMENT	$368
D6055	DENTAL IMPLANT SUPPORTED CONNECTING BAR	$540

D6056	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	$368
D6057	CUSTOM FAB ABUTMENT - INCLUDES PLACEMENT	$610
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,050
D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	$915
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	$1,050
D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	$946
D6062*	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$981
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL)	$854
D6064*	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	$1,168
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,144
D6066*	IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN	$1,083
D6067*	IMPLANT SUPPORTED METAL CROWN	$962
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	$1,026
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	$1,050
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	$965
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	$984
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	$997
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	$910
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	$967
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$1,018
D6076*	IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD	$992
D6077*	IMPLANT SUPPORTED RETAINER FOR CASE METAL FPD	$962
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS	$55
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE	$0
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	$135
D6091	REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT(MALE OR FEMALE COMPONENT) OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS	$410
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	$79
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	$124
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	$810
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	$55
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	$0
D6100	IMPLANT REMOVAL, BY REPORT	$600
D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	$0
D6102	DEBRIDEMENT & OSSEOUS PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	$0
D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT DEFECT	$350
D6104	BONE GRAFT IMPLANT REPLACEMENT	$0
D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$1,840
D6111	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$1,840
D6112	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$1,840
D6113	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$1,840
D6118	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	$0

D6119	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MAXILLARY	$0
D6190		$265
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM	$835
FIXED PROSTHODONTIC SERVICES		
D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	$0
D6210*	PONTIC - CAST HIGH NOBLE METAL	$0
D6211	PONTIC - CAST PREDOM BASE METAL	$0
D6212*	PONTIC - CAST NOBLE METAL	$0
D6214*	PONTIC TITANIUM	$0
D6240*	PONTIC-PORCELN FUSED HI NOBLE METL	$0
D6241	PONTIC-PORCLN FUSD PREDOM BASE METL	$0
D6242*	PONTIC - PORCELN FUSED NOBLE METAL	$0
D6245	PONTIC - PORCELAIN/CERAMIC	$0
D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	$0
D6251	PONTIC RESIN W/PREDOM BASE METAL	$0
D6252*	PONTIC RESIN W/NOBLE METAL	$0
D6253	PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$0
D6545	RETAINER- CASE MTL FOR RESIN FXD PROS	$0
D6548	RET-PORC/CER FOR RESIN BONDED FIXED PROS	$0
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	$0
D6600	RETAINER INLAY-PORCELAIN/CERAMIC 2 SURFACES	$0
D6601	RETAINER INLAY - PORCELN/CERAMIC 3/MORE SURF	$0
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURF	$0
D6603*	RETAINER INLAY-CAST HI NOBLE METL 3/> SURF	$0
D6604	RETAINER INLAY-CAST PREDOM BASE METL 2 SURF	$0
D6605	RETAINER INLAY-CAST PREDOM BASE METL 3/>SURF	$0
D6606*	RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	$0
D6607*	RETAINER INLAY - CAST NOBLE METL 3/MORE SURF	$0
D6608	RETAINER ONLAY - PORCELN/CERAMIC 2 SURFACES	$0
D6609	RETAINER ONLAY - PORCELN/CERAMIC 3/MORE SURF	$0
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURF	$0
D6611*	RETAINER ONLAY-CAST HI NOBLE METL 3/> SURF	$0
D6612	RETAINER ONLAY-CAST PREDOM BASE METL 2 SURF	$0
D6613	RETAINER ONLAY-CAST PREDOM BASE METL 3/>SURF	$0
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	$0
D6615*	RETAINER ONLAY - CAST NOBLE METL 3/MORE SURF	$0
D6624*	RETAINER INLAY - TITANIUM	$0
D6634*	RETAINER ONLAY - TITANIUM	$0
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$0
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$0
D6721	RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	$0
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	$0
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	$0
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$0
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$0
D6752*	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$0
D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$0
D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$0
D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	$0
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$0
D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$0
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	$0
D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	$0
D6794*	RETAINER CROWN - TITANIUM	$0
D6920	CONNECTOR BAR	$0
D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	$0
D6940	STRESS BREAKER	$0

D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	$0
ORAL SURGERY SERVICES		
D7111	XTRCT CORONL RMNNTS DECIDUOUS TOOTH	$0
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$0
D7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$0
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	$0
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	$0
D7240	REMOVAL IMPACTED TOOTH - CMPL BONY	$0
D7241	REMV IMP TOOTH-CMPL BNY W/SURG COMP	$0
D7250	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$0
D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL	$0
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$0
D7270	TOOTH REIMPL&/STBL ACC DISPLCD	$0
D7280	EXPOSURE OF AN UNERUPTED TOOTH	$0
D7280	SURGICAL ACCESS AN UNERUPTED TOOTH	$0
D7282	MOBILZ ERUPT/MALPSTN TOOTH AID ERUP	$0
D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	$0
D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	$0
D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$0
D7288	BRUSH BIOPSY	$0
D7290	SURGICAL REPOSITIONING OF TEETH	$0
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$0
D7311	ALVEOLOPLSTY CONJNC XTRCT 1-3 TEETH	$0
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$0
D7321	ALVEOLOPLSTY NOT W/XTRCT 1-3 TEETH	$0
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$0
D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	$0
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$0
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$0
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$0
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$0
D7471	REMOVAL OF LATERAL EXOSTOSIS	$0
D7472	REMOVAL OF TORUS PALATINUS	$0
D7473	REMOVAL OF TORUS MANDIBULARIS	$0
D7485	REDUCTION OF OSSEOUS TUBEROSITY	$0
D7485	SURGICAL RDUC OSSEOUS TUBEROSITY	$0
D7510	I&D ABSCESS-INTRAORAL SOFT TISS	$0
D7511	I & D ABSC INTRAORAL SOFT TISS COMP	$0
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	$0
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	$0
D7530	REMO OF FORREIGN BODY - SKIN SUBCUTANEOUS	$0
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	$0
D7960	FRENULECTOMY SEPARATE PROCEDURE	$0
D7963	FRENULOPLASTY	$0
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	$0
D7971	EXCISION OF PERICORONAL GINGIVA	$0
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	$0
ADJUNCTIVE GENERAL SERVICES		
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	$0
D9120	FIXED PARTIAL DENTURE SECTIONING	$0
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	$0
D9211	REGIONAL BLOCK ANESTHESIA	$0

D9212	TRIGEMINAL DIVISION BLOCK ANES	$0
D9215	LOCAL ANESTHESIA	$0
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA	$0
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	$0
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	$0
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	$0
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	$0
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	$0
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	$0
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	$0
D9430	OV OBS - NO OTH SERVICES PERFORMED	$0
D9440	OV-AFTER REGULARLY SCHEDULED HRS	$0
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	$0
D9940	OCCLUSAL GUARD BY REPORT	$0
D9943	OCCLUSAL GUARD ADJUSTMENT	$0
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$0
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$0
D9971	ODONTOPLASTY	$0
D9972	EXTERNAL BLEACHING - PER ARCH PERFORMED IN OFFICE	$125
D9985	SALES TAX	$0
D9995	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO DENTIST FOR SUBSEQUENT REVIEW	$0
D9996	BROKEN APPOINTMENT	$0
ORTHODONTIC SERVICES		
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION)	$750
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	$750
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	$750
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	$0
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINERS)	$150
D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF TREATMENT	$75
D8999	a START-UP FEE (INCLUDING EXAM, BEGINNING RECORDS, X-RAYS,TRACING, PHOTOS, AND MODELS)	$350
FixedProsthedontics		
D5992	ADJUST MAXILLOFACIAL PROSTHETIC APPLIANCE, BY REPORT	$0

Please review the Evidence of Coverage for additional details, including exclusions relating to the benefits listed above.

Procedures with an asterisk (*) for noble or high noble metal may require an additional fee.

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

Dental Benefit Providers of California, Inc.

Change of Address Amendment

The Address for Dental Benefit Providers of California is changed in all document instances to:

Dental Benefit Providers of California, Inc

5701 Katella Avenue

Cypress, CA 90630

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

DENTAL BENEFIT PROVIDERS OF CALIFORNIA, INC.

Kirk E. Andrews, President

Language Assistance Services

We[1] provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-800-999-3367, or the toll-free member phone number listed on your dental plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Notice of Non-Discrimination

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

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

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-800-999-3367 or the toll-free member phone number listed on your dental plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

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

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

- The patient's name and Policy number.
- The date(s) of Dental Service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a Dental care professional with experience in the field, who was not involved in the prior determination. We may consult with, or ask dental experts to take part in the appeal process. You consent to this referral and the sharing of needed dental claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

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

For procedures related with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for benefits.
- For appeals of post-service claims as identified above, the appeal will take place and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization* (*IRO*) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Dental Provider should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Dental Provider to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

DENTAL PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2022

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

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

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

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

How We Use or Disclose Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What Are Your Rights

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

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

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

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

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

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

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

Exercising Your Rights

- **Contacting your** *Dental* **Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your *dental* ID card or you may call us at 1-800-999-3367, or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

  UnitedHealthcare

  Dental HIPAA - Privacy Unit

  PO Box 30978

  Salt Lake City, UT 84130
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

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

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

FINANCIAL INFORMATION PRIVACY NOTICE

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

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2022

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

Information We Collect

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

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

Disclosure of Information

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

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

Confidentiality and Security

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

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your dental plan ID card or call us at 1-800-999-3367, or TTY 711.

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

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

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

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

Receive Information about Your Plan and Benefits

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

ERISA Statement

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

Summary Plan Description

Name of Plan: Peralta Community College District Welfare Benefit Plan

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

Peralta Community College District
333 East 8th Street
Oakland, CA 94606
(510) 466-7386

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

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

Employer Identification Number (EIN): 94-1590799

Plan Number: 501

Plan Year: July 1 through June 30

Type of Plan: Health care coverage plan

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

Peralta Community College District
333 East 8th Street
Oakland, CA 94606
(510) 466-7386

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

UnitedHealthcare
3110 Lake Center Dr
Santa Ana, CA 92704-5187

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

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

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

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

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

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