UnitedHealthcare Insurance Company

DENTAL INSURANCE

CERTIFICATE OF COVERAGE

FOR

Saint Louis Crisis Nursery

GROUP NUMBER: 1498034

EFFECTIVE DATE: July 1, 2025

DENTAL PLAN: P0204

Offered and Underwritten by

UnitedHealthcare Insurance Company

Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

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

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

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

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

Can This Certificate Change?

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

Other Information You Should Have

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

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

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

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

Introduction to Your Certificate

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

What Are Defined Terms?

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

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

How Do You Use This Document?

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

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

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

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

How Do You Contact Us?

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

Your Responsibilities

Enrollment and Required Contributions

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

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

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

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

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

Decide What Services You Should Receive

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

Choose Your Dental Provider

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

Pay Your Share

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

Pay the Cost of Excluded Services

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

File Claims with Complete and Accurate Information

When you receive Covered Dental Care Services from an out-of-Network provider, you 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.

We have the discretion to do the following:

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

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

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

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

Pay Network Providers

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

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

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with

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

Certificate of Coverage Table of Contents

Section 1: Covered Dental Care Services

When Are Benefits Available for Covered Dental Care Services?

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

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

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

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

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

One example is:

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

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

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

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

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

1. Classes of Dental Benefits

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

Class I - Dental Benefits

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

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

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

Class II - Dental Benefits

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

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

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

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

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

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

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

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

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

Class III - Dental Benefits

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

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

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

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

Class IV - Dental Benefits

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

2. Virtual Visits

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

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

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

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

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

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

3. Prenatal Dental Care

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

Credit for Prior Coverage

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

Pre-Treatment Estimate

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

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

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

Section 2: Exclusions and Limitations

We Do Not Pay Benefits for Exclusions

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

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

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

Where Are Benefit Limitations Shown?

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

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

Exclusions

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

1. Dental Care Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance).
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. Any treatment, device or pharmacological regimen that is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be an Experimental, Investigational or Unproven Service.
8. Placement of dental implants, implant-supported crowns, abutments, and prostheses.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to you by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is due to patient non-compliance, the patient is liable for the cost of replacement.
14. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
15. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice, or the notice period as required by the Dental Provider in question.
16. Expenses for Dental Procedures begun prior to you becoming enrolled under the Policy.
17. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
18. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
19. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
20. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
21. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
22. Services rendered by a provider with the same legal residence as you or who is a member of your family, including but not limited to: spouse, brother, sister, parent or child.
23. Dental Care Services otherwise covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Care Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, surgical procedure to correct a malocclusion, replacement of lost or broken retainers, and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan within 120 months of initial or supplemental placement.
26. In the event that an out-of-Network Dental Provider waives, does not pursue, or fails to collect, Co-payments, Co-insurance and/or any deductible or other amount owed for a particular dental care service, no Benefits are provided for the dental care service when the Co-payments, Co-insurance and/or deductible are waived.
27. Foreign Services are not covered unless required as an Emergency.
28. 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.

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

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

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

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

Section 3: When Coverage Begins

How Do You Enroll?

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

Who Is Eligible for Coverage?

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

Eligible Person

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

Eligible Persons must live within the United States.

Dependent

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

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

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

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

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

Open Enrollment Period

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

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

New Eligible Persons

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

Adding New Dependents

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

- Birth.

- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.

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

Special Enrollment Period

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

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

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

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

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

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

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

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

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

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

Fraud or Intentional Misrepresentation of a Material Fact

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

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

Coverage for a Disabled Dependent Child

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

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

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

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

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

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

Extended Coverage

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

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

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

Continuation of Coverage

If your coverage ends under the Policy, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal 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 Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

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

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

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

- Notifying us in a timely manner of your election of continuation coverage.

Section 5: How to File a Claim

How Are Covered Dental Care Services from Network Providers Paid?

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

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

When you receive Covered Dental Care Services from an out-of-Network provider, 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. Failure to furnish proof within the time frame shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

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 30567, Salt Lake City, UT 84130 or by fax to 248-733-6060. If you would like to use a claim form, you may access a form on the Internet at www.myuhc.com or call us at 1-800-445-9090 and a claim form will be provided to you. If you do not receive the claim form within 15 calendar days of your request, you shall be deemed to have complied with the requirements of the policy as to submitting written proof of loss covering the occurrence, character, and extent of the loss for which claim is made, within the time fixed in the policy.

Payment of Benefits

If you provide written authorization to allow this, all or a portion of any Allowed Amounts due to a provider may be paid directly to the provider instead of being paid to the Subscriber. We will not reimburse third parties that have purchased or been assigned benefits by Physicians or other Dental Providers.

Benefits will be paid to you unless either of the following is true:

- The Dental Provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

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

Section 6: Questions, Grievances and Appeals

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

What if You Have a Question?

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

What if You Have a Grievance?

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

If you would rather send your grievance 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 grievance. We will notify you of our decision regarding your grievance within 60 days of receiving it.

First Level Grievance Procedure

Call us at 800-445-9090. Representatives are available to take your call during regular business hours, Monday through Friday.

If the representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written grievance. You may also designate a representative to submit a grievance for you. The representative can provide you with the appropriate address to submit your written grievance.

- We will acknowledge receipt of the grievance in writing within 10 working days unless the grievance has been resolved prior to that time. Our authorized representative will contact you and attempt to resolve the issue through informal communications.

Investigation

We will conduct a complete investigation of the grievance within 20 working days after receipt of the grievance, unless the investigation cannot be completed within this time. If the investigation cannot be completed within 20 working days after receipt of the grievance, we will notify you in writing on or before the 20th working day, and the investigation will be completed within the next 30 working days. The notice will give the reasons why additional time is needed for the investigation.

Within 5 working days after the investigation is completed, someone not previously involved in the cause of the grievance or its investigation will decide on the appropriate resolution and notify you in writing of our decision and of any right to appeal for a second level review. The notice will explain the resolution and the right to file an appeal in terms that are clear and specific. Within 15 days after the investigation is complete, we will notify you or the person who submitted the grievance on your behalf.

Second Level by Grievance Advisory Panel

If you still disagree with our determination, you can submit a written request for a second review. Upon receipt of the request for a second review, we will submit the grievance to a grievance advisory panel consisting of:

- Other Subscribers.
- Representatives of ours that were not involved in the cause of the grievance or in any subsequent investigation or determination of the grievance.

- When the grievance involves an adverse determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed. These will be people that were not involved in the cause of the grievance or in any subsequent investigation or determination of the grievance.

Review by the grievance advisory panel will follow the same time frames as above, except for expedited review as described below.

The grievance advisory panel will advise you in writing of its findings within 15 days from the conclusion of the hearing.

At any time during this process you have the right to take your grievance to the Missouri Department of Insurance. You can contact the Missouri Department of Insurance by calling their consumer complaint hotline at 800-726-7390 or by writing to the Missouri Department of Insurance at:

Missouri Department of Insurance

Consumer Services Section

P.O. Box 690

Jefferson City, Missouri 65102-0690

Expedited Review

If you have a dispute about a health care service that if left untreated would seriously jeopardize your health or your ability to regain maximum function and requires special consideration as an expedited review, the above sections do not apply. Your expedited grievance may be submitted orally or in writing. For the purposes of the grievance register, the request will not be considered a grievance unless it is in writing. The expedited review procedures are available to you, your representative, and a provider acting on your behalf. Please note that prescheduled treatments, therapies, surgeries, or other procedures are not considered urgent situations, unless the delivery of the prescheduled medical service changes and becomes urgent.

We will notify you verbally of our determination within 72 hours after receiving a request for an expedited review. We will provide a written confirmation of our determination within 3 working days after we have verbally notified you.

If you are dissatisfied with our determination, you have the right to take your grievance to the Missouri Department of Insurance. You can contact the Missouri Department of Insurance by calling their consumer complaint hotline at 800-726-7390 or by writing to the Missouri Department of Insurance at:

Missouri Department of Insurance

Consumer Services Section

P.O. Box 690

Jefferson City, Missouri 65102-0690

How Do You Appeal a Claim Decision?

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

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

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

Appeal Process

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

Appeals Determinations

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

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

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

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

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

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

Urgent Appeals that Require Immediate Action

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

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

- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Dental Provider to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

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

Independent External Review Program

When a health carrier or their designated utilization review organization issues an adverse determination, as defined above, to a Covered Person in a health plan that has a managed care component, the Covered Person or his/her representative may file a grievance with the director without exhausting all remedies available under the carrier's grievance process.

A health carrier or plan sponsor also may file a grievance with the director concerning an adverse determination.

1. The grievance will be processed by the division as any other consumer complaint. The division will assign the grievance a file number. The division will send an inquiry to the health carrier (or party) which is complained against requesting the heath carrier (or party) to respond in writing with their position and all supporting documentation concerning the matter grieved. The division will attempt to resolve the issue with the health carrier (or party).
2. If the director determines a grievance is unresolved after completion of the division's consumer complaint process, the director will refer the unresolved grievance to an *Independent Review Organization (IRO).* An unresolved grievance will include a difference of opinion between a treating health care professional and the health carrier concerning the medical necessity, appropriateness, health care setting, and level of care or effectiveness of a health care service.
3. The director will provide the *IRO* and the Covered Person, the Covered Person's representative or health carrier, copies of all medical records and any other relevant documents which the division has received from any party. The Covered Person, the Covered Person's representative and health carrier may review all the information submitted to the *IRO* for consideration.
4. The Covered Person, the Covered Person's representative or health carrier may also submit additional information to the division which the division will forward to the *IRO*. All additional information must be received by the division. If a Covered Person, the Covered Person's representative or health carrier has information which contradicts information already provided the *IRO*, they should provide it as additional information. All additional information should be received by the division within 15 working days from the date the division mailed that party copies of the information provided the *IRO*. An envelope's postmark will determine the date of mailing. Information may be submitted to the division by means other than mail if it is in writing, typeset or easily transferred into typeset by the division's technology and a date of transmission is easily determined by the division. Any additional information submitted by the Covered Person, the Covered Person's representative will be reviewed by the *IRO* when conducting the external review. At the director's discretion, additional information which is received past the 15 working-day deadline may be submitted to the *IRO*.
5. The *IRO* will request from the division any additional information it wants. The division will gather the requested information from a Covered Person, the Covered Person's representative or health carrier or other appropriate entity and provide it to the *IRO*. If the division is unable to obtain the requested information, the *IRO* will base its opinion on the information already provided.
6. Within 20 calendar days of the receipt of the request for external review, the *IRO* will submit to the director its opinion of the issues reviewed. Under exceptional circumstances, if the *IRO* requires additional time to complete its review, it should request in writing from the director an extension in the time to process the review, not to exceed 5 calendar days. The request should include the reasons for the request and a specific time when the review is expected to be complete.

7. After the director receives the *IRO's* opinion, the director will issue a binding decision the Covered Person and the health carrier. The director's decision will be in writing and must be provided to the Covered Person and health carrier within 25 calendar days of receiving the *IRO's* opinion. In no event will the time between the date the *IRO* receives the request for external review and the date the Covered Person and the health carrier are notified of the director's decision be longer than 45 days.

Expedited External Review

A Covered Person, the Covered Person's representative or health carrier may request an expedited external review if the adverse determination:

1. Concerns an admission, availability of care, continued stay, or health care service for which the Covered Person received Emergency Health Care Services, but has not been discharged from a facility; or
2. Involves a medical condition for which the standard external review time frame would jeopardize the life or health of the Covered Person or jeopardize the his or her prognosis or ability to regain maximum function.

As expeditiously as possible after receipt of the request for expedited external review by the IRO, the IRO must issue its opinion as to whether the adverse determination should be upheld or reversed and submit its opinion to the director. As expeditiously as possible, but within no more than 72 hours after the receipt of the request for expedited external review by the IRO, the director will issue notice to the Covered Person and the health carrier of the director's determination and may issue a decision to uphold or reverse the adverse determination.

If the notice is not in writing, the director must provide the written decision within 48 hours after the date of the notice of the determination.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan**. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan**. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

Definitions

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

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

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

B. **This Plan**. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. **Order of Benefit Determination Rules**. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is

secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. **Allowable Expense**. Allowable Expense is a health care expense, including deductibles, co-insurance and co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

   The following are examples of expenses or services that are not Allowable Expenses:

   1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
   2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
   3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
   4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
   5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. **Closed Panel Plan**. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent**. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

What Are the Rules for Determining the Order of Benefit Payments?

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

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

D. Each Plan determines its order of benefits using the first of the following rules that apply:

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

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

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

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

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Important: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this Coverage Plan), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are secondary to Medicare, we will pay Benefits under this Coverage Plan as if you were covered under both Medicare Part A and Part B. As a result, your out-of-pocket costs will be higher.

If you have not enrolled in Medicare, Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider if either of the following applies:

- You are eligible for, but not enrolled in, Medicare and this Coverage Plan is secondary to Medicare.
- You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

When calculating this Coverage Plan's Benefits in these situations for administrative convenience, we may, as we determine, treat the provider's billed charges, rather than the Medicare approved amount or Medicare limiting charge, as the Allowable Expense for both this Coverage Plan and Medicare.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Does This Plan Have the Right of Recovery?

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

We will not request a refund or offset against a claim more than 12 months after the claim has been paid, except in cases of fraud or misrepresentation by the provider.

How Are Benefits Paid When This Plan is Secondary to Medicare?

If This Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits.

Section 8: General Legal Provisions

What Is Your Relationship with Us?

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

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

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

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

What Is Our Relationship with Providers and Groups?

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

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

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

The Group is solely responsible for all of the following:

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

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

What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

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

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

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

Notice

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

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber, as indicated on the attached copy of the application, shall, in the absence of fraud be deemed representations and not warranties. We will not use any statement made by the Group or Subscriber to void the Policy after it has been in force for two years unless it is a fraudulent statement. After two years, the validity of the Policy may only be contested due to nonpayment of premiums.

Are Incentives Available to You?

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

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

Who Interprets Benefits and Other Provisions under the Policy?

We have the discretion to do all of the following:

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

- Make factual determinations related to the Policy and its Benefits.

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

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

Who Provides Administrative Services?

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

Amendments to the Policy

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 Policy.

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

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

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

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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

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

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

- Required by law or regulation.

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

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

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

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

Do We Require Examination of Covered Persons?

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

Is Workers' Compensation Affected?

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

When Do We Receive Refunds of Overpayments?

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

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

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

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 Policy. 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 Policy; or (ii) future Benefits that are payable 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.

We will not request a refund or offset against a claim more than 12 months after the claim has been paid except in cases of fraud or misrepresentation by the provider.

Is There a Limitation of Action?

We strongly encourage you to complete the steps specified in Section 6: Questions, Grievances and Appeals prior to bringing any legal proceeding or action against us. After completing that process, after

the expiration of 60 days after the proof of loss, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

What Is the Entire Policy?

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

Section 9: Defined Terms

Allowed Amounts - Allowed Amounts for Covered Dental Care Services, incurred while the Policy is in effect, are determined as stated below:

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

B. For out-of-Network Benefits, when Covered Dental Care Services are received from out-of-Network Dental Providers, Allowed Amounts are our contracted fee(s) for Covered Dental Care Services with a Network Dental Provider in the same geographic area.

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

Annual Deductible - the total of the Allowed Amount you must pay for Covered Dental Care Services in a calendar year before we will begin paying for Network or out-of-Network Benefits in that calendar year. It does not include any amount that exceeds Allowed Amounts. The Schedule of Covered Dental Care Services will tell you if your plan is subject to an Annual Deductible.

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

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

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

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

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

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

- The Co-payment.
- The Allowed Amount.

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

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

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

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

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

Dependent - the Subscriber's legal spouse 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 Policy, a Dependent must reside within the United States. The term "child" includes:

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

The following conditions apply:

- A Dependent includes an unmarried child listed above under age 26.
- A resident of Missouri.
- A Dependent includes an unmarried child age 26 or older who is or becomes disabled and dependent upon the Subscriber.
- Not provided coverage as named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Medicare.

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

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

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

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

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

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

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

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

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

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

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

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

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

Maximum Policy Benefit - the maximum amount paid for Network and Out-of-Network Benefits during the entire period of time that you are covered under the Policy or any Policy, issued by us to the Enrolling Group, that replaces the Policy. The Maximum Policy Benefit is stated in the Schedule of Covered Dental Care Services.

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

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

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

A. needed to meet your basic dental needs; and

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

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

D. consistent with the diagnosis of the condition; and

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

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

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

    2. safe with promising efficacy:

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

b. in a clinically controlled research setting; and

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

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

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

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

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

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.

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 Policy. The Group sets the period of time that is the Open Enrollment Period.

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

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

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

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

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

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

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

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

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

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

Schedule of Covered Dental Care Services

How Do You Access Benefits?

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

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

Network Dental Providers

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

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

Directory of Network Dental Providers

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

Network and out-of-Network Benefits

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

Network Benefits

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

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

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

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

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

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

Coverage for Dental Care Services is subject to payment of the Premium required for Coverage under the Policy, satisfaction of any applicable deductible, payment of the Co-insurance specified for any service and payment of the percentage of Allowed Amounts shown in this *Schedule of Covered Dental Care*

Services and generally require you to pay less to the Dental Provider than out-of-Network Benefits. Network Benefits are determined based on the contracted fee for each Covered Dental Care Service. In no event will you be required to pay a Network Dental Provider an amount for a Covered Dental Care Service in excess of the contracted fee.

Network Benefits:

When Network Co-insurance is charged as a percentage of Allowed Amounts, the amount you pay for Dental Care Services from Network Dental Provider is determined as a percentage of the negotiated contract fee between us and the Dental Provider rather than a percentage of the Dental Provider's billed charge. Our negotiated rate with the Dental Provider is ordinarily lower than the Dental Provider's billed charge.

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

Out-of-Network Benefits:

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

Before you are eligible for Coverage of Dental Care Services obtained from out-of-Network Dental Providers, you must meet the requirements for payment of the applicable deductible stated below. Generally you are required to pay more than Network Benefits. Out-of-Network Dental Providers may request that you pay all charges when services are rendered. You must file a claim with us for reimbursement of Allowed Amounts.

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

Classes of Dental Benefits

Listed below are the class categories of Covered Dental Care Services. The table below will provide information on your specific benefits and class of the dental care service. Any Covered Dental Care Service in one class can be shifted to another class.

Class I - Dental Benefits:

- Diagnostic Services
- Preventive Services
- Radiographs
- Space Maintainers

Class II - Dental Benefits:

- Adjunctive Services
- Endodontic Services
- Minor Restorative Services
- Oral Surgery Services
- Periodontic Services

Class III - Dental Benefits:

- Cosmetic Procedures
- Major Restorative Services
- Prosthodontic Services
- Removable Dentures

Class IV - Dental Benefits:

- Orthodontic Services

BENEFIT DESCRIPTION & LIMITATION	**NETWORK CO-INSURANCE** Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	**OUT-OF-NETWORK CO-INSURANCE** Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
CLASS I **DIAGNOSTIC SERVICES** EXCEPT CONE BEAMS		
Bacteriologic Cultures	0%	0%
Viral Cultures	0%	0%
Intraoral Bitewing Radiographs Images Limited to 1 series of images per calendar year.	0%	0%
Panorex Radiographs Image Limited to 1 time per consecutive 36 months.	0%	0%
Oral/Facial Photographic Images Limited to 1 time per consecutive 36 months.	0%	0%
Cone Beam CT Capture and Interpretation with Limited Field of View - Less than One Whole Jaw Limited to 1 time every consecutive 60 months.	50%	50%
Cone Beam CT Capture and	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Interpretation with Field of View of One Full Dental Arch-Mandible Limited to 1 time every consecutive 60 months.		
Cone Beam CT Capture and Interpretation with Field of View of One Full Dental Arch-Maxilla, With and Without Cranium Limited to 1 time every consecutive 60 months.	50%	50%
Cone Beam CT Capture and Interpretation with Field of View of Both Jaws, With and Without Cranium Limited to 1 time every consecutive 60 months.	50%	50%
Diagnostic Casts Limited to 1 time per consecutive 24 months.	0%	0%
Extraoral Radiographs Images Limited to 2 images per calendar year.	0%	0%
Intraoral - Complete Series of Radiograph Images Limited to 1 time per consecutive 36 months. Vertical bitewings can not be billed in conjunction with a complete series.	0%	0%
Intraoral Periapical Radiographs Image	0%	0%
Pulp Vitality Tests Limited to 1 charge per visit,	0%	0%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
regardless of how many teeth are tested.		
Intraoral Occlusal Radiographs Image Limited to 2 images per consecutive 6 months.	0%	0%
Vertical Bitewings, 7-8 Radiograph Images Limited to 1 series of images per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series.	0%	0%
Periodic Oral Evaluation Limited to 2 times per consecutive 12 months.	0%	0%
Comprehensive Oral Evaluation Limited to new patients or 2 times per consecutive 12 months. Not covered if done in conjunction with other exams.	0%	0%
Limited or Detailed Oral Evaluation Limited to 2 times per consecutive 12 months. Only 1 exam is covered per date of service.	0%	0%
Comprehensive Periodontal Evaluation - new or established patient Limited to 2 times per consecutive 12 months.	0%	0%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Oral Evaluation for a Patient under three Years of Age and Counseling Primary Caregiver Limited to 2 times per consecutive 12 months. Not covered if done in conjunction with other exams.	0%	0%
Teledentistry - synchronous; real-time encounter Limited to 2 times per consecutive 12 months.	0%	0%
Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review Limited to 2 times per consecutive 12 months.	0%	0%
Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures Limited to 1 time per consecutive 12 months.	0%	0%
CLASS I **PREVENTIVE SERVICES**		
Dental Prophylaxis Limited to 2 times per consecutive 12 months.	0%	0%
Fluoride Treatments - child Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive	0%	0%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
12 months.		
Sealants Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	0%	0%
Preventive Resin Restoration in a Moderate to High Caries Risk Patient - Permanent Tooth Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	0%	0%
CLASS I **SPACE MAINTAINERS**		
Space Maintainers Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	0%	0%
Re-Cementation of Space Maintainers Limited to 1 per consecutive 6 months after initial insertion.	0%	0%
Removal of Fixed Space Maintainer	0%	0%
CLASS II **MINOR RESTORATIVE SERVICES**		

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Amalgam Restorations Multiple restorations on one surface will be treated as a single filling.	20%	20%
Composite Resin Restorations - Anterior Multiple restorations on one surface will be treated as a single filling.	20%	20%
Gold Foil Restorations Multiple restorations on one surface will be treated as a single filling.	20%	20%
CLASS II **ENDODONTICS**		
Apexification Limited to 1 time per tooth per lifetime.	20%	20%
Apicoectomy Limited to 1 time per tooth per lifetime.	20%	20%
Retrograde Filling Limited to 1 time per tooth per lifetime.	20%	20%
Hemisection Limited to 1 time per tooth per lifetime.	20%	20%
Root Canal Therapy Limited to 1 time per tooth per lifetime. Dentist cannot charge	20%	20%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
retreatment codes on tooth treated for the first 12 months.		
Retreatment of Previous Root Canal Therapy Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	20%	20%
Root Resection/Amputation Limited to 1 time per tooth per lifetime.	20%	20%
Therapeutic Pulpotomy Limited to 1 time per primary or secondary tooth per lifetime.	20%	20%
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration) Limited to 1 per tooth per lifetime. Covered for anterior or posterior teeth only.	20%	20%
Pulp Caps - Direct/Indirect - excluding final restoration Not covered if utilized solely as a liner or base underneath a restoration.	20%	20%
Pulpal Debridement, Primary and Permanent Teeth Limited to 1 time per tooth per lifetime. Not covered on the same day as other endodontic services.	20%	20%
Pulpal Regeneration - (Completion of Regenerative	20%	20%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Treatment in an Immature Permanent Tooth with a Necrotic Pulp) does not include Final Restoration Limit 1 per tooth per lifetime.		
CLASS II **PERIODONTICS**		
Crown Lengthening Limited to 1 per quadrant or site per consecutive 36 months.	20%	20%
Gingivectomy/Gingivoplasty Limited to 1 per quadrant or site per consecutive 36 months.	20%	20%
Gingival Flap Procedure Limited to 1 per quadrant or site per consecutive 36 months.	20%	20%
Osseous Graft Limited to 1 per quadrant or site per consecutive 36 months.	20%	20%
Osseous Surgery Limited to 1 per quadrant or site per consecutive 36 months.	20%	20%
Guided Tissue Regeneration Limited to 1 per quadrant or site per consecutive 36 months.	20%	20%
Soft Tissue Surgery Limited to 1 per quadrant or site per consecutive 36 months.	20%	20%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Surgical Revision Procedure Limited to 1 per quadrant per consecutive 36 months.	20%	20%
Periodontal Maintenance Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.	20%	20%
Full Mouth Debridement Limited to once per consecutive 36 months.	20%	20%
Provisional Splinting Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.	20%	20%
Scaling and Root Planing Limited to 1 time per quadrant per consecutive 24 months.	20%	20%
Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report Limited to 3 sites per quadrant or 12 sites total for refractory pockets or in conjunction with Periodontal Scaling and Root	20%	20%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Planing		
CLASS II **ORAL SURGERY**		
Alveoloplasty	20%	20%
Biopsy Limited to 1 biopsy per site per visit.	20%	20%
Frenectomy/Frenuloplasty	20%	20%
Surgical Incision Limited to 1 per site per visit.	20%	20%
Removal of a Benign Cyst/Lesions Limited to 1 per site per visit.	20%	20%
Removal of Torus Limited to 1 per site per visit.	20%	20%
Root Removal, Surgical Limited to 1 time per tooth per lifetime.	20%	20%
Simple Extractions Limited to 1 time per tooth per lifetime.	20%	20%
Surgical Extraction of Erupted Teeth or Roots Limited to 1 time per tooth per lifetime.	20%	20%
Surgical Extraction of Impacted	20%	20%

BENEFIT DESCRIPTION & LIMITATION	**NETWORK CO-INSURANCE** Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	**OUT-OF-NETWORK CO-INSURANCE** Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Teeth Limited to 1 per tooth per lifetime.		
Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth Limited to 1 per tooth per lifetime.	20%	20%
Primary Closure of a Sinus Perforation Limited to 1 per tooth per lifetime.	20%	20%
Placement of Device to Facilitate Eruption of Impacted Tooth Limited to 1 time per tooth per lifetime.	20%	20%
Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report Limited to 1 time per tooth per lifetime.	20%	20%
Vestibuloplasty Limited to 1 time per site per consecutive 60 months.	20%	20%
Bone Replacement Graft for Ridge Preservation - per site Limited to 1 per site per lifetime. Not covered if done in conjunction with other bone graft replacement procedures.	20%	20%
Excision of Hyperplastic Tissue or Pericoronal Gingiva Limited to 1 per site per consecutive 36 months.	20%	20%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Appliance Removal (not by dentist who placed appliance) includes removal of arch bar Limited to once per appliance per lifetime.	20%	20%
Tooth Reimplantation and/or Transplantation Services Limited to 1 per site per lifetime.	20%	20%
CLASS II **ADJUNCTIVE SERVICES**		
Analgesia Covered when Necessary in conjunction with Covered Dental Care Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	20%	20%
Desensitizing Medicament	20%	20%
General Anesthesia Covered when Necessary in conjunction with Covered Dental Care Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	20%	20%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Local Anesthesia Not Covered in conjunction with operative or surgical procedure.	20%	20%
Intravenous Sedation and Analgesia Covered when Necessary in conjunction with Covered Dental Care Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	20%	20%
Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report	20%	20%
Occlusal Adjustment	20%	20%
Occlusal Guards Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.	20%	20%
Occlusal Guard Reline and Repair Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	20%	20%
Occlusion Analysis - Mounted Case	20%	20%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Limited to 1 time per consecutive 60 months.		
Emergency Palliative Treatment Covered as a separate benefit only if no other services, other than the exam and radiographs, were done on the same tooth during the visit.	20%	20%
Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.) Not covered if done with exams or professional visit.	20%	20%
CLASS III **MAJOR RESTORATIVE SERVICES** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Coping Limited to 1 per tooth per consecutive 60 months. Not covered if done at the same time as a crown on same tooth.	50%	50%
Crowns - Retainers/Abutments Limited to 1 time per tooth per consecutive 60 months. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%	50%
Crowns - Restorations Limited to 1 time per tooth per	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.		
Temporary Crowns - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes.	50%	50%
Inlays/Onlays - Retainers/Abutments Limited to 1 time per tooth per consecutive 60 months. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%	50%
Inlays/Onlays - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%	50%
Pontics Limited to 1 time per tooth per consecutive 60 months.	50%	50%
Retainer-Cast Metal for Resin Bonded Fixed Prosthesis Limited to 1 time per consecutive	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
60 months.		
Pin Retention Limited to 2 pins per tooth; not Covered in addition to cast restoration. Cast Restoration is defined as inlays and onlays Limited to 1 time per consecutive 60 months.	50%	50%
Post and Cores Covered only for teeth that have had root canal therapy.	50%	50%
Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core Limited to 1 per consecutive 12 months. Limited to those performed more than 12 months after the initial insertion.	50%	50%
Protective Restoration Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.	50%	50%
Stainless Steel Crowns Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	50%	50%
CLASS III		

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
FIXED PROSTHETICS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Fixed Partial Dentures (bridges) Limited to 1 time per tooth per consecutive 60 months.	50%	50%
CLASS III **REMOVABLE PROSTHETICS** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Full Dentures Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	50%	50%
Partial Dentures Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	50%	50%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	50%	50%
Tissue Conditioning - Maxillary or Mandibular Limited to 1 time per consecutive 12 months.	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	50%	50%
CLASS III **COSMETIC**		
Labial Veneer (laminate) - Chairside Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	50%	50%
Labial Veneer (resin laminate) - Laboratory Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	50%	50%
Labial Veneer (porcelain laminate) -Laboratory Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	50%	50%
CLASS IV **ORTHODONTICS** Orthodontic services are subject to the applicable Waiting Period, satisfaction of any Deductible and any orthodontic Deductible, and payment of any applicable Copayments. Benefits will be paid in monthly installments on a schedule determined by the Enrolling Group over the		

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.		
Orthodontic Services Services or supplies furnished by a dentist to a Dependent under age 19 in order to diagnose or correct misalignment of the teeth or the bite. The extended coverage provision does not apply to orthodontic services.	50%	50%
Appliance Therapy, Fixed or Removable Limited to 1 time per consecutive 60 months. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.	50%	50%
Cephalometric Radiographic Image Limited to 1 per consecutive 12 months. Can only be billed for orthodontics.	50%	50%

Covered Dental Care Services are subject to satisfaction of any applicable Deductibles, Maximum Benefits and payment of any Co-insurance as stated below.

Cost Share: Deductibles and Benefit Maximums

Deductible

Annual Deductible is $50 per Covered Person for Network Benefits and $50 per Covered Person for out-of-Network Benefits per calendar year.

The Annual Deductible will not exceed $150 for Network Benefits and $150 for out-of-Network Benefits for all Covered Persons in a family per calendar year.

The Annual Deductible does not apply to: DIAGNOSTIC SERVICES and PREVENTIVE SERVICES, ORTHODONTICS.

Maximum Benefit is $1,000 per Covered Person for Network Benefits and $1,000 per Covered Person for out-of-Network Benefits per calendar year.

The Maximum Benefit applies to: ALL COVERED DENTAL CARE SERVICES.

Maximum Policy Benefit

The Maximum Policy Benefit is $1,000 per Covered Person.

Maximum Policy Benefit applies to: ORTHODONTICS.

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

Second Level Grievance Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Second Level by Grievance Advisory Panel language in the *Certificate of Coverage* is removed and replaced with the following language:

Second Level by Grievance Advisory Panel

If you still disagree with our determination, you can submit a written request for a second review. Upon receipt of the request for a second review, we will submit the grievance to a grievance advisory panel consisting of:

- Other Subscribers; and
- Representatives of ours that were not involved in the cause of the grievance or in any subsequent investigation or determination of the grievance.
- When the grievance involves an adverse determination, and the grievance advisory panel makes a preliminary decision that the determination should be upheld, the health carrier shall submit the grievance for review to two independent clinical peers in the same or similar specialty as would typically manage the case being reviewed who were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance. In the event that both independent reviews concur with the grievance advisory panel's preliminary decision, the panel's decision shall stand. In the event that both independent reviewers disagree with the grievance advisory panel's preliminary decision, the initial adverse determination shall be overturned. In the event that one of the two independent reviewers disagrees with the grievance advisory panel's preliminary decision, the panel shall reconvene and make a final decision in its discretion.

Review by the grievance advisory panel will follow the same time frames as above, except for expedited review as described below.

The grievance advisory panel will advise you in writing of its findings within 15 days from the conclusion of the hearing.

At any time during this process you have the right to take your grievance to the Missouri Department of Insurance. You can contact the Missouri Department of Insurance by calling their consumer complaint hotline at 800-726-7390 or by writing to the Missouri Department of Insurance at:

Missouri Department of Insurance

Consumer Services Section

P.O. Box 690

Jefferson City, Missouri 65102-0690

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

UnitedHealthcare Insurance Company

Robert Hunter, President

Language Assistance Services

ATTENTION: If you speak English, free language assistance services and free communications in other formats, such as large print, are available to you. Call 1-800-445-9090. (TTY: 711).

ATENCIÓN: 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)សេវាជំនួយភាសាគោយឥតគិតថ្លៃ 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

УВАГА: Якщо ви розмовляєте українською мовою (Ukrainian), у вас є можливість скористатися безкоштовними послугами перекладача. Зателефонуйте, будь ласка, за номером 1-800-445-9090.

AADACHT: Wann du Deitsch Schwetze (Pennsylvanian Dutch) kann, kannscht du frei Schprooch aushilfe griege. Ruf Nummer 1-800-445-9090.

FAAALIGA: Afai e te tautala Faa-Samoa (Samoan), o loo avanoa tautua mo fesoasoani tau gagana mo oe, e le totogia. Faamolemole telefoni le 1-800-445-9090.

NOTICE OF NON-DISCRIMINATION

We comply with applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race color, national origin, age, disability or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, please call 1-800-445-9090.or the toll-free member phone number on your member ID card, TTY/RTT 711.

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

If you need help filing a complaint, please call 1-800-445-9090.or the toll-free member phone number listed on your dental member ID card, TTY/RTT 711.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

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

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

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

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

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

Claims and Appeal Notice

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

Benefit Determinations

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

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

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

Appeal Process

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

Appeals Determinations

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

For procedures related with urgent requests for Benefits, *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

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, 2025

We are required by law to protect the privacy of your health information. We are also required to provide 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 that is currently in effect.

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. 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.

How We Collect, Use, and Disclose Information

We collect, 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 confirm we are meeting our privacy obligations.

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

- **For Payment** of premiums owed to us, to determine your dental coverage, and to process claims for health care services you receive, including for coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage for certain dental procedures and what percentage of the bill may be covered.
- **For Treatment,** including to aid in your treatment or the coordination of your care. For example, we may share information with other doctors to help them provide medical care to you.
- **For Health Care Operations,** as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws.

- **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. We also may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes;** however, we will not use or disclose your genetic information for such purposes. For example, we may use some health information in risk rating and pricing such as age and gender, as permitted by state and federal regulations. However, we do not use race, ethnicity, language, gender identity, or sexual orientation information in our underwriting process, or for denial of services, coverage, and benefits.
- **For Reminders,** we may collect,use and disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You** about treatment, payment or health care operations using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances and subject to certain requirements:

- **As Required by Law** to follow the laws that apply to us.
- **To Persons Involved with Your Care** or who help 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 interest. Special rules apply regarding when we may disclose health information about a deceased individual to family members and others. 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. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
- **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** 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 federal privacy law requirements, or for certain activities related to preparing a research study.
- **To Provide Information Regarding Decedents** to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also use and disclose information to funeral directors as needed to carry out their duties.
- **For Organ Donation Purposes** 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.
- **Additional Restrictions on Use and Disclosure.** Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information. Such laws may protect the following types of information:
    1. Alcohol and Substance Use Disorder
    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 or Sexual Health
    11. Sexually Transmitted Diseases

We will follow the more stringent and protective law, where it applies to us.

Except for uses and disclosures described 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 marketing communications, without your written authorization. Once you give us authorization to use or dislose your health 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. For information on how to revoke your 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** our uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures of your information 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. Any request for restrictions must be made in writing. **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 request for a 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 in accordance with applicable state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you to 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 request 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 have the right to request that we send a copy of your health information in an electronic format to you. 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. 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. We will respond to your request in the timeframe required under applicable law. In certain circumstances, we may deny your request. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to request 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. Any request for an accounting must be made in writing.
- **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.
- **In certain states, you may have the right to request that we delete your personal information. Depending on your state of residence, you may have the right to request the deletion of your personal information. We will respond to your request in the timeframe required under applicable law. In certain circumstances, we may deny your request. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.**

Exercising Your Rights

- **Contacting your Dental Plan.** If you have any questions about this notice or want information about how to exercise your rights, please call the toll- free member phone number on your dental ID card or you may call us at 1-800-445-9090, or TTY 711.

- **Submitting a Written Request.** To exercise any of your rights described above, mail your written requests to us at the following address:

  UnitedHealthcare

  Dental HIPAA - Privacy Unit

  PO Box 30567

  Salt Lake City, UT 84130

- **Filing a Complaint or Grievance.** If you believe your privacy rights have been violated, you may file a complaint or grievance 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.

[1]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, 2025

We[2] 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 non-affiliated 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 non-affiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

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

Questions about this Notice

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

[2]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, on the last 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 $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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.