

United Dental Care of Texas, Inc.
3595 Grandview Parkway, Suite 650
Birmingham, AL 35243
800-443-2995

EVIDENCE OF COVERAGE

ARTICLE I
DEFINITIONS

- 1.1 **Agreement**: The Group Dental Service Agreement between Group and Company and related documents constituting the entire contract under which Plan Benefits are provided to Members.
- 1.2 **Anniversary Date**: Agreement's first Anniversary Date is the day after the initial Plan Year ends, as stated in Agreement. The Anniversary Date occurs on the same date in each subsequent year, as stated in Agreement.
- 1.3 **Company**: United Dental Care of Texas, Inc.
- 1.4 **Copayment**: Shall mean a per-service fee charged to Member by Plan Provider as identified in the Copayment Schedule.
- 1.5 **Dental Emergency**: A dental condition of recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.
- 1.6 **Dependent**: Subscriber's spouse and Subscriber's natural children from and after moment of birth, adopted children from date of placement (or from the date Subscriber becomes a party in a suit in which the adoption of the child by Subscriber is sought, if that is earlier), grandchildren, children for whom Subscriber has a temporary or permanent court order granting conservatorship or guardianship, children for whom Subscriber is required to provide coverage by a medical-support court order, stepchildren and foster children. To be eligible, all such children must be under age twenty-five (25) years (the "Limiting Age") and unmarried. To be eligible, stepchildren and foster children must also be chiefly dependent on Subscriber for maintenance and support. Eligibility may be extended past the Limiting Age for unmarried children who are not capable of self-sustaining employment due to a disability or physical handicap and chiefly dependent on Subscriber for maintenance and support. If Company requests proof of a Dependent's eligibility, Subscriber must furnish proof within 31 days of Company's request. Company will not require proof of a Dependent's continuing eligibility more than once a year.
- 1.7 **Effective Date**: The date Agreement becomes effective, as stated in Agreement.
- 1.8 **Emergency Services**: Those procedures administered in a dentist's office, dental clinic, or other comparable facility to evaluate and stabilize a dental condition that is a Dental Emergency.
- 1.9 **Group**: Shall mean the employer, association, or other organization identified in Agreement.
- 1.10 **Member**: Shall mean a Subscriber or Dependent enrolled in Plan.
- 1.11 **Non-Plan Dentist**: A general dentist who is not a Plan Dentist.
- 1.12 **Non-Plan Provider**: A Non-Plan Dentist or a Non-Plan Specialty Dentist, or a hygienist or technician acting with or assisting such a dentist.
- 1.13 **Non-Plan Specialty Dentist**: A dentist practicing in a dental specialty who is not a Plan Specialty Dentist.
- 1.14 **Plan Benefits**: Shall mean benefits for services provided under Agreement, subject to any limitations and exclusions.

- 1.15 **Plan Dentist:** Shall mean a licensed General Dentist who, at time Plan Benefits are provided, is under contract with Company to provide certain dental services to Members. Copayments listed in the **PLAN DENTIST SERVICES** Section of the Copayment Schedule apply only to Plan Dentists who perform the corresponding services listed in the Copayment Schedule. The Plan Dentist selected by Member may not perform all listed services. In order to fully understand payment responsibility for dental services, Member should discuss availability of services and the proposed treatment and its cost with selected Plan Dentist prior to receiving treatment.
- 1.16 **Plan Provider:** Shall mean a Plan Dentist or Plan Specialty Dentist who, at time Plan Benefits are provided, is under contract with Company to provide services to Members. The term shall include any hygienists and technicians recognized by the dental profession who act with and assist Plan Dentist or Plan Specialty Dentist. A list of Plan Providers shall be published in Plan Dentist Directory. Company has sole discretion to determine which providers may be Plan Providers. Plan Providers are independent contractors in private practice and are neither employees nor agents of Company. Company cannot guarantee that any specific provider will be a Plan Provider. The status of providers as Plan Providers is subject to change.
- 1.17 **Plan Specialty Dentist:** Shall mean a licensed dentist practicing in a dental specialty who, at time Plan Benefits are provided, is under contract with Company to provide dental specialty services to Members. Some examples of dental specialties are endodontics, periodontics, oral surgery, orthodontics, and pedodontics. Each Plan Specialty Dentist will participate in only one of the following two categories:
- Non-Specialty-Benefit Plan Specialty Dentist (or Non-SB Plan Specialty Dentist)** - offers any dental specialty service he provides to Members at a specific reduction from his normal retail charge.
- Specialty-Benefit Plan Specialty Dentist (or SB Plan Specialty Dentist)** - offers certain dental specialty services he provides to Members for specified Copayments (services and Copayments listed in the **SPECIALTY DENTIST SERVICES** Section of the Copayment Schedule) and offers all other dental specialty services he provides to Members at a specific reduction from his normal retail charge.
- In order to fully understand payment responsibility for dental specialty services, Member should discuss the proposed treatment and its cost with Plan Specialty Dentist prior to receiving treatment. Availability of specific types of specialty services from SB or Non-SB Plan Specialty Dentists depends on which types of dentists are SB or Non SB Plan Specialty Dentists. Company cannot guarantee that any specific type of dentist will be an SB or Non SB Plan Specialty Dentist. Types of dentists who are SB or Non SB Plan Specialty Dentists may vary from time to time in different parts of the Service Area. Copayments listed in the **SPECIALTY DENTIST SERVICES** Section of the Copayment Schedule apply only to SB Plan Specialty Dentists who perform the corresponding services listed in the Copayment Schedule. The SB Plan Specialty Dentist selected by Member may not perform all listed services.
- 1.18 **Plan Year:** Agreements initial Plan Year begins on the Effective Date and last for the number of months stated in Agreement. Each subsequent Plan Year of Agreement begins on the Anniversary Date and lasts for a period of twelve (12) calendar months.
- 1.19 **Prepayment Fee:** The periodic, prospectively determined rate or fee paid to Company for each Member's coverage.
- 1.20 **Service Area:** The geographic area where Plan Benefits are available. The extent of the Service Area is within the sole discretion and determination of Company.
- 1.21 **Subscriber:** Shall mean an employee, member or beneficiary of Group who is eligible to participate in Plan under the eligibility requirements determined by Group.

**ARTICLE II
ELIGIBILITY AND MEMBER EFFECTIVE DATE**

- 2.1 **Eligibility:** Subscriber and his Dependent(s) are eligible to become Members of Plan during the open enrollment period set by Group. For Subscribers who become eligible after the Effective Date, eligibility shall be subject to Group's eligibility rules. Each Member (except a Dependent child for whom Subscriber must provide coverage under a medical-support court order) must work or live in Plan Service Area to participate in Plan.

If an additional Prepayment Fee is required for coverage of Subscriber's newly born natural child or Subscriber's child newly placed for adoption, and if Subscriber wishes to have the child covered as of the date of birth or placement, Group must notify Company and pay the additional Prepayment Fee within thirty-one (31) days after that date.

- 2.2 **Coverage of Members / Effective Date:** Each Subscriber or Dependent whose Prepayment Fee has been accepted by Company on or before the 20th day of the month will be covered beginning the first day of the following month. Each Subscriber or Dependent whose Prepayment Fee has been accepted by Company after the 20th day, but by the last day, of a month will be covered beginning the first day of the second following month.

**ARTICLE III
MEMBER'S COPAYMENTS**

- 3.1 **Member's Copayments and Other Charges:** Member is responsible for payment of all Copayments, any additional laboratory fees for certain dental services as stated in the Copayment Schedule, and all charges for services that are not Plan Benefits. Member must pay dental provider at the time service is rendered. Member may have an option to pay according to provider's billing procedures.

**ARTICLE IV
BENEFITS AND COVERAGES**

- 4.1 **Assignment of Benefits:** Member's coverage is intended for the sole use and benefit of Member and cannot be transferred to a third party.
- 4.2 **Plan Benefits:** Company shall provide benefits for dental services to Members as set forth in the Evidence of Coverage and Copayment Schedule. Services are subject to limitations and exclusions. Services are provided for the term of Agreement. Company reserves the right to change Plan Benefits after the initial Plan Year. Notice of change is subject to sixty (60) days written notice.
- 4.3 **Current Dental Terminology:** Plan Benefits will be based on the most current dental terminology. From time to time, and with at least thirty (30) days written notice to Group, Company reserves the right to update Agreement to reflect the most current dental terminology.
- 4.4 **Provision of Plan Benefits / Plan Providers:** Except as specifically provided in the **EMERGENCY SERVICES** Article of the Evidence of Coverage and the **SPECIALTY DENTIST SERVICES** Section of the Copayment Schedule, Agreement provides only for services performed by a Plan Provider. Except as specifically provided in the **EMERGENCY SERVICES** Article of the Evidence of Coverage and the **SPECIALTY DENTIST SERVICES** Section of the Copayment Schedule, Company shall not have any liability due to treatment by any non-Plan Provider. In addition, Company shall not have any liability due to treatment by any physician, hospital, other person, institution or group. Each Member shall select a Plan Dentist from the Plan Dentist Directory furnished by Group to Member. Specialty services covered by Plan may be obtained from a Plan Specialty Dentist or Non-Plan Specialty Dentist. Agreement provides for services

only. It is not an insurance policy. It does not reimburse Member or Group except as specifically provided in the **EMERGENCY SERVICES** Article of the Evidence of Coverage and the **SPECIALTY DENTIST SERVICES** Section of the Copayment Schedule.

4.5 **Selection of Provider:**

- A. **Plan Dentist:** Each Member shall select a Plan Dentist from Plan Dentist Directory. To obtain Plan Benefits, Member shall contact selected Plan Dentist.

Change of Selected Plan Dentist: Member or Plan Dentist may request a change of Plan Dentist selection by contacting Company. Change requests received by the 20th day of a month will be effective on the first day of the next following month. Change requests received after the 20th day of a month will be effective the first day of the second following month. Plan Benefits will not be available for services from the newly-selected Plan Dentist until the change request is received and implemented by Company.

- B. **Plan Specialty Dentist:** If Member requires specialty services that cannot be provided by Member's selected Plan Dentist, Member may obtain services from a Plan Specialty Dentist or a Non-Plan Specialty Dentist. No referral from the selected Plan Dentist is needed. Member's out-of-pocket amount may vary depending on whether services are received from an SB Plan Specialty Dentist, a Non-SB Plan Specialty Dentist, or a Non-Plan Specialty Dentist.

- 4.6 **Member/Plan Provider Relationship:** The relationship between Member and Plan Provider shall be an independent professional one. Plan Provider shall be solely responsible, without intrusion by Company or Group for all services within the professional relationship between Member and Plan Provider. Plan Provider has the right to refuse treatment to any Member who: (1) fails to follow a prescribed course of treatment; (2) fails to keep confirmed appointments; (3) fails or refuses to make required payments (including but not limited to Copayments, laboratory fees or missed appointment fees as noted in the Copayment Schedule) or any charges for non covered procedures; (4) uses the relationship for illegal purposes; or (5) otherwise makes the professional relationship unduly burdensome. Company has the right to refuse Plan Benefits to any Member by terminating coverage as stated in the **Member Termination** section of the **TERMINATION** article of the Evidence of Coverage

- 4.7 **Providers not participating with Plan:** Company does not review practice standards of Non-Plan Providers. Members who obtain services from Non-Plan Providers should separately assess the practice standards and skills of those providers.

**ARTICLE V
LIMITATIONS AND EXCLUSIONS**

- 5.1 **Pre-Existing Conditions:** Agreement's exclusions and limitations apply with respect to Member's oral conditions without regard to whether or not such conditions existed before the effective date of Member's enrollment for Plan Benefits.

- 5.2 **Exclusions:** Plan Benefits are not available for:

A. Any services not specifically described in the Copayment Schedule (including but not limited to any hospital or outpatient care facility cost associated with any dental service). However, the reference to "hospital or outpatient care facility" does not include a dentist's office, dental clinic, or other comparable facility when the services described in the Copayment Schedule qualify as Emergency Services as defined in the Evidence of Coverage.

B. Any part of any dental service for which a charge is incurred before the effective date of Member's enrollment for Plan Benefits. This exclusion means only that payment of the incurred charge, at the provider's entire normal retail cost for that part of that service,

remains the Member's responsibility after the Member enrolls for Plan Benefits.

- C. Any dental service initiated after Member's enrollment for Plan Benefits ends.
 - D. Services provided by Non-Plan Providers unless (a) for services of Non-Plan Specialty Dentists as specifically provided in the **SPECIALTY DENTIST SERVICES** Section of the Copayment Schedule or (b) for Emergency Services as specifically provided in the **EMERGENCY SERVICES** Article of the Evidence of Coverage.
 - E. Replacement of bridgework, dentures or other fixed or removable appliances unless (a) at least five (5) years have elapsed since such appliances was provided as a Plan Benefit, or (b) during that five (5) year period, appliance becomes unusable and can not be made usable due to Member's illness or an accident involving damage to the appliance while it is in use.
 - F. Replacement of dentures or other removable appliances due to (a) damage while not in use or (b) loss or theft.
 - G. Oral reconstruction using fixed bridgework or other fixed appliances if the overall treatment plan to achieve complete oral reconstruction involves the replacement of six (6) or more teeth (whether those teeth are missing before treatment begins or are extracted as part of the overall treatment plan.)
 - H. Implants or any related implant appliances, or surgery for the insertion of implants or any related implant appliances, whether fixed or removable.
 - I. Surgical removal of implants or implant appliances, or any surgical or non-surgical services to adjust, repair, replace, or treat any problem related to an existing implant or implant appliance, whether fixed or removable.
 - J. Restorations or splints used to increase vertical dimension, restore occlusion, or replace or stabilize tooth structure lost by attrition.
 - K. Orthodontic Treatment involving therapy for myofunctional problems, TMJ (temporomandibular joint) dysfunctions, micrognathis, macroglossia, cleft palate or other growth and developmental abnormalities.
 - L. Orthodontic treatment associated with orthognathic surgery, whether the treatment precedes or follows the surgery.
 - M. Extractions of third molars (wisdom teeth) that are not symptomatic, whether or not the extractions follow the completion of orthodontic treatment. Examples of symptomatic conditions include decay, odontogenic cysts, chronic pericoronitis and infection.
 - N. Treatment for malignancies, neoplasms or cysts, including but not limited to biopsies.
- 5.3 **Orthodontic Extractions:** Extractions by a Plan Provider for solely orthodontic purposes are not subject to the fixed Copayments shown for extractions in the Copayment Schedule. Instead, such extractions are subject to charges reflecting a 25% reduction from that Plan Provider's normal retail charges for such extractions.
- 5.4 **Services of Non-Plan Specialty Dentists:** Plan Benefit payments for services of Non-Plan Specialty Dentists, as provided in the **SPECIALTY DENTIST SERVICES** Section of the Copayment Schedule, are limited to a total of \$2000.00 per calendar year.

ARTICLE VI EMERGENCY SERVICES

- 6.1 **If Selected Plan Dentist is Available:** A Member who has a Dental Emergency should seek care

from his or her selected Plan Dentist. Plan Benefits apply to all services of the Member's selected Plan Dentist as stated in the **PLAN DENTIST SERVICES** Section of the Copayment Schedule.

- 6.2 **If Selected Plan Dentist Is Not Available:** If a Member has a Dental Emergency and the Member's selected Plan Dentist is not available, the Member may seek and receive Emergency Services from any other licensed dentist within the United States of America. Company will reimburse only the expenses for Emergency Services (as defined in the Evidence of Coverage) that are listed in the **PLAN DENTIST SERVICES** Section of the Copayment Schedule and provided by such dentist, less the Copayment amounts that would have applied to the same services provided by Member's selected Plan Dentist.
- 6.3 **Expense Reimbursement:** Reimbursement of expenses for Emergency Services is subject to the following conditions:
- A. The only expenses eligible for reimbursement are expenses for services provided by a dentist (other than Member's selected Plan Dentist) within the United States of America, where the services both: (1) are listed in the PLAN DENTIST SERVICES Section of the Copayment Schedule; and (2) qualify as Emergency Services as stated in the definition of "Emergency Services" in the **DEFINITIONS** Article of the Evidence of Coverage. Such services are also subject to the same limitations and exclusions (as listed in the Evidence of Coverage) that would apply to services provided by Member's selected Plan Dentist.
 - B. Services administered in a hospital or outpatient care facility other than a dentist's office, dental clinic, or other comparable facility do not qualify as Emergency Services as defined in the Evidence of Coverage. Therefore, reimbursement is not available for such hospital's or outpatient care facility's charges.

ARTICLE VII DENTAL CHARGES PAID BY MEMBERS

- 7.1 Company does not reimburse Member except for benefits for Emergency Services as specifically stated in the **EMERGENCY SERVICES** Article of the Evidence of Coverage and for certain Non-Plan Specialty Dentist services as specifically stated in the **SPECIALTY DENTIST SERVICES** Section of the Copayment Schedule. Reimbursement of Member expenses for such services is subject to the following conditions:
- A. **Proof of Expenses.** Member must furnish satisfactory written proof of covered expenses to Company. This must be within sixty (60) days after receipt of the services for which Member seeks reimbursement. Member should send reimbursement requests, with satisfactory written proof of covered expenses to:

**Dental Claims
P.O. Box 2940
Clinton, Iowa 52733**

- B. **Failure to Furnish Proof of Expenses.** Failure to furnish proof to Company within the required time shall not nullify or reduce reimbursement. This is true: (1) only if it was not reasonably possible to provide proof within such time and (2) if proof is furnished as soon as reasonably possible.
- C. **Reimbursement of Expenses.** Reimbursement requests will be processed within forty-five (45) days of Company's receipt of satisfactory written proof of expenses. This applies unless Member is notified of the need for additional time. If reimbursement is denied, written notice shall be given to Member within forty-five (45) days of Company's receipt of request. Such notice will contain the reasons for denial.

- D. Limitations of Actions. No action at law or equity shall be brought under this Article against Company prior to the end of the ninety (90) day period following the date on which satisfactory written proof of the expenses has been furnished to Company. No such action shall be brought later than three (3) years after the ending of the period of time in which such proof of expenses must be furnished to Company.

ARTICLE VIII MEMBER APPEALS PROCESS

- 8.1 **Resolution Procedures:** Any inquiry, complaint or grievance shall be made by contacting Company or Plan Provider. Members should take any question or concern directly to Plan Provider rendering service to resolve the issue immediately. Company inquiries or dissatisfactions may be conveyed by telephone or in writing.
- A. Verbal Complaint: Member may contact Company Customer Service department regarding any inquiry, complaint or grievance that cannot be resolved to Member's satisfaction. This occurs after speaking directly with the dentist or other concerned party. Company Customer Service Representative will assess and resolve Member's concern. If Member is not satisfied with the resolution, Member may file a written complaint to Company. Company Customer Service Representative will provide Member with the guidelines. In addition, such representative will provide complaint form to be completed.
- B. Written Complaint: Company expects receipt of a completed complaint form or correspondence from Member expressing dissatisfaction with service or care delivered by Company or Plan Dentist. Once this occurs, Company will acknowledge the written complaint within five (5) business days. Company will investigate the complaint and will provide a written resolution to Member within (30) calendar days. In matters of quality of care or clinical issues, an appropriate health professional will be consulted. If the complaint is not resolved to Member's satisfaction, Company shall provide an appeal procedure.
- C. Appeal Procedure: If Member is not satisfied with the resolution of a written complaint, Member may request an appeal of Company's assessment by submitting a written request to Company. Within five (5) days of receipt, Company will send Member an acknowledgement of receipt of Member's request for appeal, which shall include information regarding the appeal process and Member's right to appear before the appeal panel. Company will conduct an investigation of the appeal involving persons who did not participate in the initial resolution of the written complaint. In matters concerning quality of care, an appropriate health care professional will be consulted. At the conclusion of the investigation, Company will notify Member of Company's decision. In all cases, the Member will receive written notice containing the final determination of the appeal panel. The notice shall include the specific dental judgement and/or contractual criteria used to reach the final decision and the address and toll-free number of the Texas Department of Insurance. The appeals process shall be completed within thirty (30) days after receipt of Member's request for appeal.
- D. Complaints Regarding Emergency Services: Notwithstanding any provision in the Agreement to the contrary, investigation and resolution of complaints regarding presently occurring Emergency Services shall be concluded in accordance with the immediacy of the case and shall not exceed twenty-four (24) hours from receipt of Member's complaint.

ARTICLE IX TERMINATION

- 9.1 **Termination of Eligibility:** If Subscriber is terminated or leaves Group, Subscriber and his Dependents shall continue to be covered until Company is notified in writing of Subscriber's

termination.

9.2 **Member Termination:** Member coverage shall terminate as follows:

- A. On the last day of the month for which Group has placed Member on eligibility list and has paid Member's proper Prepayment Fee.
- B. If Member commits fraud or material misrepresentation in the use of services or facilities, coverage for Member will terminate upon fifteen (15) days written notice.
- C. If Member commits fraud or material misrepresentation on the Enrollment Form, coverage will terminate upon fifteen (15) days written notice. This provision will not be enforced after two (2) years from the time Member's coverage began.
- D. If Group or Company terminates Agreement, coverage for Member shall cease on the termination date of Agreement. This shall be subject to any notice required by state law.
- E. If any Member fails or refuses to make required payments to Plan Providers, including but not limited to Copayments for provided services, Company reserves the right to terminate coverage upon sixty (60) days written notice. Prepayment Fees received for terminated Member for the period after termination date shall be refunded to Group. Thereafter, Company shall have no further liability or responsibility to Member.
- F. A Member, after reasonable efforts, may be unable to establish a satisfactory dentist-patient relationship with a Plan Provider. If so, Company reserves the right to terminate coverage upon sixty (60) days written notice. Prepayment Fees received for terminated Member for the period after termination date shall be refunded to Group. Thereafter, Company shall have no further liability or responsibility to Member.
- G. Coverage for Subscriber's Dependents will be terminated if the coverage for Subscriber terminates for any reason. This is subject to continuation privileges for certain Dependents as set forth herein.
- H. Once a Member is no longer qualified as a Dependent, coverage for that Member will terminate.
- I. If Member (except a Dependent child for whom Subscriber must provide coverage under a medical support court order) no longer works or lives in Plan Service Area, coverage will terminate upon thirty (30) days written notice.
- J. Upon misconduct detrimental to safe plan operation and delivery of services, Member's coverage may be terminated immediately.

**ARTICLE X
CONTINUATION OF COVERAGE / COBRA**

- 10.1 **Services in Progress at Termination:** If Member's enrollment ends for any reason, each Plan Provider is required to complete all dental services initiated prior to the date Member's enrollment ends. Member's financial responsibility for such services is determined according to the terms of Agreement in effect on the last day of Member's enrollment.
- 10.2 **Continuation of Coverage under COBRA:** If under the provisions of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99-272, Member is granted the right to continue coverage beyond the date Member's coverage would otherwise terminate, the following applies. Agreement shall be deemed to allow coverage to continue to comply with the provisions of applicable statutes. Member should contact Group concerning eligibility.
- 10.3 Continuation of Coverage: (If continuation of coverage under COBRA is also available, this

provision applies upon completion of any such continuation.) Any Member whose coverage under Agreement has been terminated for any reason except involuntary termination for cause, and who has been continuously covered under Agreement or under any group contract providing similar services and benefits which it replaces for at least three consecutive months immediately prior to termination shall be entitled to the continuation privilege as outlined below. Involuntary termination for cause does not include termination for any health-related cause.

- A. Continuation of group coverage under Agreement must be requested in writing within thirty-one (31) days following the later of: (a) the date the group coverage would otherwise terminate; or (b) the date the Member is given notice of the right of continuation by the Group.
- B. A Member electing continuation must pay to the Group on a monthly basis, in advance, the amount of contribution required by the Group, plus two percent of the group rate for the coverage being continued under the Agreement, on the due date of each payment.
- C. The Member's written election of continuation, together with the first contribution required to establish further contributions on a monthly basis, in advance, must be given to the Group within thirty-one (31) days following the later of (a) the date the group coverage would otherwise terminate or (b) the date the Member is given notice of the right of continuation by the Group.
- D. Continuation may not terminate until the earliest of (a) six (6) months after the date the election is made, (b) the date on which failure to make timely payments would terminate coverage, (c) the date on which the Member is covered for similar services and benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or any other program, or (d) the date on which the Agreement terminates in its entirety.

ARTICLE XI GENERAL PROVISIONS

- 11.1 **Amendments:** Company reserves the right to modify, amend or alter Agreement. Any such change will be in writing and duly executed by Company, except to the extent Company updates Plan Benefits to be based on the most current dental terminology.
- 11.2 **Distribution of Plan Materials and Notices to Members:** Company may be obligated under state law to give notice or Plan materials to Member. If so, it shall be sufficient for Company to give notice or Plan materials to the Group's delegate, unless state law requires otherwise. Group shall then be responsible for providing notice or Plan materials to Subscribers.
- 11.3 **Circumstances Beyond Company's Control:** Rendition of dental services may be delayed or made impractical due to circumstances not within Company's control. If this occurs, neither Company nor Plan Provider shall have any liability or obligation to provide services on account of such delay. This includes, but is not limited to, complete or partial destruction of facilities, war, riot, and civil insurrection. It also includes labor disputes or disability of a significant number of Plan Providers.
- 11.4 **Major Disaster or Epidemic:** If a major disaster or epidemic occurs, Plan Provider shall render dental services as practical according to his judgment. Such disaster or epidemic may limit available facilities or personnel. In such situation, neither Company nor Plan Provider shall have any liability or obligation for delay or failure to provide dental services.

TO CONTACT CUSTOMER SERVICE, CALL 1-800-443-2995

United Dental Care of Texas, Inc.
3595 Grandview Parkway, Suite 650
Birmingham, AL 35243
800-443-2995

PLUS PLAN WITH SPECIALTY BENEFIT COPAYMENT SCHEDULE

SECTION I: PLAN DENTIST SERVICES
(Subject to Limitations and Exclusions Listed in Evidence of Coverage)

Plan Benefits are provided for the dental services listed in this **Plan Dentist Services** Section of the Copayment Schedule only when services are provided by Member's selected Plan Dentist. Limited benefits for Emergency Services from other Plan Dentists are provided as specifically stated in the **EMERGENCY SERVICES** Article of the Evidence of Coverage. Plan Benefits are not available for dental services that do not appear on the Copayment Schedule. To fully understand the benefits, exclusions and limitations of this plan, Member should consult the Evidence of Coverage.

Member is responsible for paying the amount listed in the **Member Copayment** column, plus any additional laboratory ("lab") fees for certain dental services. Payment may be due at the time the service is received or in accordance with Plan Dentist's billing procedures. Lab fees may apply to services with an asterisk (*). For such a service, the lab fee is that Plan Dentist's normal retail lab fee for that service.

Plan Benefits will be based on the most current dental terminology. Company reserves the right to update the Copayment Schedule to reflect the most current dental terminology, with at least thirty (30) days written notice to Group.

The Plan Dentist selected by Member may not perform all listed services. To fully understand payment responsibility for dental services, Member should discuss availability of services, the proposed treatment, and cost with selected Plan Dentist prior to treatment. Company cannot guarantee that any specific general dentist will be a Plan Dentist.

Any Plan Dentist may (but is not required to) charge any Member for any missed appointment, in accordance with the Plan Dentist's guidelines, if Member fails to notify the Plan Dentist at least 24 hours before the scheduled appointment time. However, the charge to the Member may not exceed \$25.00 per missed appointment.

Payment for all services received from a Non-Plan Dentist (at the Non-Plan Dentist's entire normal retail charge) is the responsibility of Member, except for benefits for Emergency Services as specifically stated in the EMERGENCY SERVICES Article of the Evidence of Coverage.

ADA Code	Service Description **	Member Copayment
	<u>Appointments</u>	
None	Office visit – during regularly scheduled hours***	No Charge
D9440	Office visit - after regularly scheduled office hours	40.00
D0120	Periodic oral evaluation (ADA D0120 may only be obtained once in any six calendar months, except for medically necessary more frequent evaluations as determined by Member's Plan Dentist)	No Charge
D0140	Limited oral evaluation, problem focused	20.00

ADA Code	Service Description **	Member Copayment
D0150	Comprehensive oral evaluation - new or established patient (ADA Code D0150 may only be obtained once in any six calendar months, except for medically necessary more frequent evaluations as determined by Member's Plan Dentist)	No Charge
D0160	Detailed and extensive oral evaluation - problem focused	15.00
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	15.00
D0180	Comprehensive periodontal evaluation - new or established patient	15.00
D9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	55.00
<u>Diagnostic Dentistry</u>		
D0210	X-Ray: intraoral - complete series, including bitewings (ADA Code D0210 may only be obtained once in any three calendar years, except for medically necessary more frequent x-rays as determined by Member's Plan Dentist.)	No Charge
D0220	X-Ray: intraoral - periapical first film	No Charge
D0230	X-Ray: intraoral - periapical each additional film	No Charge
D0240	X-Ray: intraoral - occlusal film	No Charge
D0250	X-Ray: extraoral - first film	No Charge
D0260	X-Ray: extraoral - each additional film	No Charge
D0270	X-Ray: bitewing - single film	No Charge
D0272	X-Ray: bitewing - two films (ADA Code D0272 may only be obtained once in any six calendar months, except for medically necessary more frequent e-rays as determined by Member's Plan Dentist.)	No Charge
D0274	X-Ray: bitewing - four films (ADA Code D0274 may only be obtained once in any six calendar months, except for medically necessary more frequent e-rays as determined by Member's Plan Dentist.)	No Charge
D0277	X-Ray: vertical bitewings - 7 to 8 films	No Charge
D0330	X-Ray: panoramic film (ADA Code D0330 may only be obtained once in any three calendar years, except for medically necessary more frequent e-rays as determined by Member's Plan Dentist.)	5.00
D0415	Collection of micro-organisms for culture and sensitivity	No Charge
D0425	Caries susceptibility tests	No Charge
D0460	Pulp vitality tests	No Charge
<u>Preventive Dentistry</u>		
D1110	Prophylaxis - adult (ADA Code D1110 may only be obtained once in any six calendar months, except for medically necessary more frequent prophylaxis as determined by Member's Plan Dentist)	No Charge
D1120	Prophylaxis - child up to age 18 (ADA Code D1110 may only be obtained once in any six calendar months, except for medically necessary more frequent prophylaxis as determined by Member's Plan Dentist)	No Charge
D1203	Topical application of fluoride - child up to age 18 (prophylaxis not included)	No Charge
D1310	Nutritional counseling for control of disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth	10.00
D1510	Space maintainer - fixed - unilateral*	60.00
D1515	Space maintainer - fixed - bilateral*	60.00
D1520	Space maintainer - removable - unilateral*	85.00
D1525	Space maintainer - removable - bilateral*	105.00
D1550	Re-cementation of space maintainer	15.00
None	Additional prophylaxis*** (Additional prophylaxis does not apply to patients with periodontal disease)	25.00
D9940	Occlusal guards, by report	85.00

ADA Code	Service Description **	Member Copayment
D9951	Occlusal adjustment – limited	30.00
D9952	Occlusal adjustment – complete	145.00
<u>Restorative Dentistry</u>		
D2140	Amalgam - one surface, primary or permanent	10.00
D2150	Amalgam - two surfaces, primary or permanent	15.00
D2160	Amalgam - three surfaces, primary or permanent	25.00
D2161	Amalgam - four or more surfaces, primary or permanent	35.00
D2330	Resin-based composite - one surface, anterior	30.00
D2331	Resin-based composite - two surfaces, anterior	40.00
D2332	Resin-based composite - three surfaces, anterior	50.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	65.00
D2391	Resin-based composite - one surface, posterior	60.00
D2392	Resin-based composite - two surfaces, posterior	70.00
D2393	Resin-based composite - three surfaces, posterior	80.00
D2394	Resin-based composite - four or more surfaces, posterior	110.00
D2510	Inlay - metallic - one surface*	102.00
D2520	Inlay - metallic - two surfaces*	125.00
D2530	Inlay - metallic - three or more surfaces*	150.00
D2542	Inlay- metallic - two surfaces*	215.00
D2543	Onlay - metallic - three surfaces*	220.00
D2544	Onlay - metallic - four or more surfaces*	220.00
D2610	Inlay - porcelain/ceramic - one surface*	200.00
D2620	Inlay - porcelain/ceramic - two surfaces*	210.00
D2630	Inlay - porcelain/ceramic - three or more surfaces*	220.00
D2740	Crown - porcelain/ceramic substrate*	275.00
D2750	Crown - porcelain fused to high noble metal*	275.00
D2751	Crown - porcelain to predominantly base metal*	275.00
D2752	Crown - porcelain fused to noble metal*	275.00
D2790	Crown - full cast high noble metal*	275.00
D2791	Crown - full cast predominantly base metal*	275.00
D2792	Crown - full cast noble metal*	275.00
D2910	Recement inlay, onlay or partial coverage restoration	15.00
D2920	Recement crown	15.00
D2930	Prefabricated stainless steel crown - primary tooth	80.00
D2940	Sedative filling	15.00
D2950	Core buildup, including any pins	75.00
D2951	Pin retention - per tooth, in addition to restoration	15.00
D2952	Cast post and core in addition to crown*	90.00
D2954	Prefabricated post and core in addition to crown	80.00
D2962	Labial veneer (porcelain laminate) - laboratory*	290.00
D2980	Crown repair, by report*	25.00
None	Temporary filling***	15.00
<u>Endodontics</u>		
D3110	Pulp cap - direct (excluding final restoration)	15.00
D3120	Pulp cap - indirect (excluding final restoration)	10.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	40.00
D3310	Root canal therapy: anterior (excluding final restoration)	90.00
D3320	Root canal therapy: bicuspid (excluding final restoration)	165.00
D3330	Root canal therapy: molar (excluding final restoration)	175.00

ADA Code	Service Description **	Member Copayment
D3346	Retreatment of previous root canal therapy - anterior	320.00
D3347	Retreatment of previous root canal therapy - bicuspid	380.00
D3348	Retreatment of previous root canal therapy - molar	460.00
D3410	Apicoectomy/periradicular surgery - anterior	125.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	170.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	220.00
D3426	Apicoectomy/periradicular surgery (each additional root)	100.00
D3430	Retrograde filling - per root	40.00
D3450	Root amputation - per root	70.00
D3920	Hemisection (including any root removal), not including root canal therapy	80.00
<u>Periodontics</u>		
D4210	Gingivectomy or gingivoplasty - 4 + contiguous or bounded teeth spaces per quadrant	120.00
D4211	Gingivectomy or gingivoplasty - 1 to 3 teeth, per quadrant	65.00
D4240	Gingival flap procedure, including root planing – 4 + contiguous or bounded teeth spaces per quadrant	140.00
D4241	Gingival flap procedure including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	100.00
D4260	Osseous surgery (including flap entry and closure) 4+ contiguous or bounded teeth spaces per quadrant	350.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces, per quadrant	203.00
D4320	Provisional splinting – intracoronal	80.00
D4321	Provisional splinting – extracoronal	75.00
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	45.00
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	27.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	50.00
D4910	Periodontal maintenance	45.00
None	Periodontal hygiene instructions***	No Charge
<u>Removable Prosthodontics (Dentures)</u>		
D5110	Complete denture - maxillary*	295.00
D5120	Complete denture - mandibular*	295.00
D5130	Immediate denture - maxillary*	400.00
D5140	Immediate denture - mandibular*	400.00
D5211	Maxillary partial denture - resin base*	355.00
D5212	Mandibular partial denture - resin base*	355.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases*	365.00
D5214	Mandibular partial denture - cast metal framework with resin denture base* (D5211 - D5214 includes any conventional clasps, rests, and teeth)	365.00
D5410	Adjust complete denture – maxillary	15.00
D5411	Adjust complete denture – mandibular	15.00
D5421	Adjust partial denture – maxillary	15.00
D5422	Adjust partial denture – mandibular	15.00
D5510	Repair broken complete denture base*	30.00
D5610	Repair resin denture base*	35.00
D5620	Repair cast framework*	35.00
D5630	Repair or replace broken clasps	35.00
D5640	Repair broken teeth - per tooth	35.00
D5650	Add tooth to existing partial denture	35.00
D5730	Reline complete maxillary denture (chairside)	60.00
D5731	Reline complete mandibular denture (chairside)	60.00

ADA Code	Service Description **	Member Copayment
D5740	Reline maxillary partial denture (chairside)	60.00
D5741	Reline mandibular partial denture (chairside)	60.00
D5750	Reline complete maxillary denture (laboratory)*	95.00
D5751	Reline complete mandibular denture (laboratory)*	95.00
D5760	Reline maxillary partial denture (laboratory)*	95.00
D5761	Reline mandibular partial denture (laboratory)*	95.00
D5850	Tissue conditioning, maxillary	25.00
D5851	Tissue conditioning, mandibular	25.00
D5862	Precision attachment, by report*	145.00
<u>Fixed Prosthodontics (Bridges or Fixed Partial Dentures)</u>		
D6210	Pontic - cast high noble metal*	275.00
D6211	Pontic - cast predominantly base metal*	275.00
D6212	Pontic - cast noble metal*	275.00
D6240	Pontic - porcelain fused to high noble metal*	275.00
D6241	Pontic - porcelain fused to predominantly base metal*	275.00
D6242	Pontic - porcelain fused to noble metal*	275.00
D6251	Pontic - resin with predominantly base metal*	275.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis*	140.00
D6721	Crown - resin with predominantly base metal*	275.00
D6750	Crown - porcelain fused to high noble metal*	275.00
D6751	Crown - porcelain fused to predominantly base metal*	275.00
D6752	Crown - porcelain fused to noble metal*	275.00
D6780	Crown - 3/4 cast high noble metal*	275.00
D6790	Crown - full cast high noble metal*	275.00
D6791	Crown - full cast predominantly base metal*	275.00
D6792	Crown - full cast noble metal*	275.00
D6930	Recement fixed partial denture	15.00
D6940	Stress breaker	150.00
D6950	Precision attachment, by report	195.00
D6980	Fixed partial denture repair, by report*	45.00
None	Resin bonded bridge pontic, per unit***(*)	235.00
<u>Oral Surgery</u>		
D7111	Extraction, coronal remnants – deciduous tooth	15.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	15.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	50.00
D7220	Removal of impacted tooth - soft tissue	60.00
D7230	Removal of impacted tooth - partially bony	75.00
D7240	Removal of impacted tooth – completely bony	100.00
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	135.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	40.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	100.00
D7280	Surgical access of an unerupted tooth	85.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant	60.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	90.00
D7510	Incision and drainage of abscess – intraoral soft tissue	35.00
D7960	Frenulectomy (frenectomy or frenotomy) separate procedure	125.00
<u>Bleaching</u>		
D9972	External Bleaching per arch	155.00

ADA Code	Service Description **	Member Copayment
	<u>Emergency Treatment of Pain</u>	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	25.00
	<u>Anesthesia, Analgesia, and Sedation</u>	
D9220	Deep sedation/general anesthesia – first 30 minutes	180.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide - per 30 minutes	15.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	165.00
D9242	Intravenous conscious sedation/analgesia -each additional 15 minutes	35.00

SECTION II: SPECIALTY DENTIST SERVICES
(Subject to Exclusions and Limitations Listed in Evidence of Coverage)

If Member requires dental specialty services that cannot be provided by selected Plan Dentist, Member may obtain such services from an SB Plan Specialty Dentist, a Non-SB Plan Specialty Dentist, or a Non-Plan Specialty Dentist. No referral from Member's selected Plan Dentist is needed. However, Member's out-of-pocket expense may vary depending on whether services are received from an SB Plan Specialty Dentist, a Non-SB Plan Specialty Dentist or a Non-Plan Specialty Dentist. Member responsibilities for obtaining services from these three categories of specialty dentists are described below.

To fully understand payment responsibility for dental specialty services, Member should discuss the proposed treatment and its cost with the specialty dentist prior to treatment. Availability of specified types of specialty services from an SB or Non-SB Plan Specialty Dentist depends on which types of dentists are SB or Non-SB Plan Specialty Dentists. Types of dentists who are SB or Non-SB Plan Specialty Dentist may vary from time to time in different parts of the Service Area. Company cannot guarantee that any specific dentist, or any specific type of dentist, will be an SB or Non-SB Plan Specialty Dentist. Listed Copayments apply only to SB Plan Specialty Dentists who perform the corresponding services listed in the Copayment Schedule. The SB Plan Specialist used by Member may not perform all listed services.

- A. **SB Plan Specialist Services on Copayment Schedule:** The following Copayment Schedule applies to covered services when they are provided by an SB Plan Specialty Dentist. Member is responsible for paying the amount in the Member Copayment column either at the time the service is received or in accordance with SB Plan Specialty Dentist's billing procedures.

ADA Codes	Service Description	Member Copayment
<u>Appointments</u>		
D0140	Limited oral evaluation, problem focused	35.00
D0150	Comprehensive oral evaluation - new or established patient (ADA Code D0150 may only be obtained once in any six calendar months, medically necessary more frequent evaluations as determined by the attending SB Plan Specialty Dentist)	45.00
D0160	Detailed and extensive oral evaluation, problem focused, by report	67.00
D0170	Re-evaluation- limited, problem focused, (established patient, not post-operative visit)	35.00
D0180	Comprehensive periodontal evaluation - new or established patient	80.00
<u>Endodontics</u>		
D3320	Root canal therapy: bicuspid (excluding final restoration)	280.00
D3330	Root canal therapy: molar (excluding final restoration)	395.00
D3346	Retreatment of previous root canal therapy - anterior	360.00
D3347	Retreatment of previous root canal therapy - bicuspid	525.00
D3348	Retreatment of previous root canal therapy - molar	545.00
D3410	Apicoectomy/periradicular surgery - anterior	265.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	280.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	310.00
D3430	Retrograde filling, per root	90.00
<u>Periodontics</u>		
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	335.00
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	100.00
D4260	Osseous Surgery (including flap entry and closure) Four + teeth per quadrant	495.00

ADA Codes	Service Description	Member Copayment
D4261	Osseous Surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces, per quadrant	215.00
D4341	Periodontal scaling and root planning - four or more teeth per quadrant	100.00
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	70.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	80.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	50.00
<u>Oral Surgery</u>		
D7210	Surgical removal of erupted tooth	80.00
D7220	Removal of impacted tooth - soft tissue	105.00
D7230	Removal of impacted tooth - partial bony	135.00
D7240	Removal of impacted tooth - complete bony	200.00
D7241	Removal of impacted tooth - complete bony with complications	220.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	75.00
D7310	Alveoloplasty in conjunction with extractions, per quadrant	180.00
D7320	Alveoloplasty not in conjunction with extractions, per quadrant	130.00
D7510	Incision and drainage of abscess, intraoral soft tissue	105.00
D7960	Frenulectomy (frenectomy or frenotomy) separate procedure	185.00
<u>Analgesia and Sedation</u>		
D9241	Intravenous conscious sedation / analgesia, first 30 minutes	170.00

B. **SB Plan Specialty Dentist Services Not on Copayment Schedule and Non-SB Plan Specialty Dentist Services:** Dental services obtained from an SB Plan Specialty Dentist, but not listed on the Copayment Schedule above, and dental services obtained from a Non-SB Plan Specialty Dentist will be provided to Member at reduced charges. A 15% reduction from that Plan Specialty Dentist's normal retail charges applies to services obtained from a Plan Specialty Dentist whose practice is limited to endodontics. A 25% reduction from that Plan Specialty Dentist's normal retail charges applies to services obtained from any other Plan Specialty Dentist (including, but not limited to, a Plan Specialty Dentist whose practice is orthodontics). Member will be responsible for paying the entire reduced charge either at the time the service is received, or in accordance with Plan Specialty Dentist's billing procedures.

C. **Non-Plan Specialty Dentist Services on Plan Benefit Schedule (Subject to a \$2,000.00 Limit Paid by Company in Any Calendar Year):** The following Plan Benefit Schedule applies to covered services when they are provided by a Non-Plan Specialty Dentist. Member is responsible for paying that specialty dentist's entire normal retail charge for the service at the time the service is received or in accordance with specialty dentist's billing procedures. Member may then submit a completed claim form, with an itemized bill attached, to Company. (Member may obtain claim forms by contacting Company) Company will pay Member lesser of the amount shown in "Maximum Company Reimbursement " column or the amount charged by the specialist for the service.

ADA Codes	Service Description	Maximum Company Reimbursement
<u>Appointments</u>		
D0140	Limited oral evaluation, problem focused	20.00
D0150	Comprehensive oral evaluation - new or established patient (ADA Code D0150 may only be obtained once in any six calendar months, except for medically necessary more frequent evaluations as determined by attending Non-Plan Specialty Dentist.)	25.00

ADA Codes	Service Description	Maximum Company Reimbursement
D0160	Detailed and extensive oral evaluation, problem focused, by report	45.00
D0170	Re-evaluation- limited, problem focused, (established patient, not post-operative visit)	25.00
D0180	Comprehensive periodontal evaluation - new or established patient	50.00
<u>Endodontics</u>		
D3320	Root canal therapy: bicuspid (excluding final restoration)	320.00
D3330	Root canal therapy: molar (excluding final restoration)	405.00
D3346	Retreatment of previous root canal therapy - anterior	230.00
D3347	Retreatment of previous root canal therapy - bicuspid	265.00
D3348	Retreatment of previous root canal therapy - molar	345.00
D3410	Apicoectomy/periradicular surgery – anterior	335.00
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	420.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	390.00
D3430	Retrograde filling, per root	85.00
<u>Periodontics</u>		
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	195.00
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	65.00
D4260	Osseous Surgery (including flap entry and closure) Four + teeth per quadrant	395.00
D4261	Osseous Surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces, per quadrant	170.00
D4341	Periodontal scaling and root planning - four or more teeth per quadrant	90.00
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	65.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	50.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	30.00
<u>Oral Surgery</u>		
D7210	Surgical removal of erupted tooth	120.00
D7220	Removal of impacted tooth - soft tissue	125.00
D7230	Removal of impacted tooth - partial bony	155.00
D7240	Removal of impacted tooth - complete bony	130.00
D7241	Removal of impacted tooth - complete bony with complications	180.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	125.00
D7310	Alveoloplasty in conjunction with extractions, per quadrant	70.00
D7320	Alveoloplasty not in conjunction with extractions, per quadrant	150.00
D7510	Incision and drainage of abscess, intraoral soft tissue	55.00
D7960	Frenulectomy (frenectomy or frenotomy) separate procedure	145.00
<u>Analgesia and Sedation</u>		
D9241	Intravenous conscious sedation / analgesia, first 30 minutes	115.00

D. **Non-Plan Specialty Dentist Services Not on Plan Benefit Schedule:** Plan Benefits are not available for any service that is both (a) received from a Non-Plan Specialty Dentist and (b) not listed on the Plan Benefit Schedule above. Payment of the Non-Plan Specialty Dentist's entire normal retail charge for each such service is the responsibility of Member, except for benefits for Emergency Services as specifically stated in the Emergency Services Article of the Evidence of Coverage.

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***Service does not have an American Dental Association current dental terminology code or nomenclature/descriptor.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL, DENTAL AND VISION INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Our Commitment

Union Security Insurance Company and its affiliated prepaid dental companies* are committed to protecting the personal information entrusted to us by our customers. The trust you place in us when you share your personal information is a responsibility we take very seriously and is the cornerstone of how we conduct our business.

We use the brand name "Assurant Employee Benefits" to associate our products and services and to connect us with the brand of our parent company, Assurant, Inc.

The Health Insurance Portability and Accountability Act (HIPAA) provides us and our affiliates with guidelines and standards to follow when we use or disclose your Protected Health Information (PHI). This new law also gives you, our customer, numerous rights regarding your ability to see, inspect, and copy your PHI. Because our commitment to privacy means complying with all privacy laws, we are providing you this notice outlining our privacy practices. The following information is intended to help you understand what we can and cannot do with your PHI and what your rights are under HIPAA.

II. Our Use and Disclosure of Your PHI

HIPAA allows us to use and disclose your PHI for treatment, payment, and dental or vision care operations without asking your permission. For instance, we may disclose information to a dental or vision provider to assist the provider in properly treating you or a dependent (Treatment). We may disclose certain information to the dental or vision provider in order to properly pay a claim or to your employer in order to collect the correct premium amount (Payment). We may disclose your information in order to help us make the correct underwriting decision or to determine your eligibility (Operations).

Other examples of possible disclosures for purposes of dental or vision care operations include:

- Underwriting our risk and determining rates and premiums for your dental or vision plan;
- Determining your eligibility for benefits;
- Reviewing the competence and qualifications of dental care or other providers;
- Conducting or arranging for dental review, legal services, and auditing functions, including fraud and abuse detection and compliance;
- Business planning and development;
- Business management and general administrative duties such as cost-management, customer service, and resolution of internal grievances;
- Other administrative purposes.

We can also make disclosures under the following circumstances without your permission:

- As required by law, including response to court and administrative orders, or to report information about suspected criminal activity;
- To report abuse, neglect, or domestic violence;

- To authorities that monitor our compliance with these privacy requirements;
- To coroners, medical examiners, and funeral directors;
- For research and public health activities, such as disease and vital statistic reporting;
- To avert a serious threat to health or safety;
- To the military, certain federal officials for national security activities, and to correctional institutions;
- To the entity sponsoring your group dental or vision plan but only for purposes of enrollment, disenrollment, eligibility or for the purpose of giving the plan sponsor summary information when necessary to help make decisions regarding changes to the plan. If the plan sponsor has certified that its plan documents have been amended to include certain privacy provisions, we may also disclose protected health information to the plan sponsor to carry out plan administration functions that the plan sponsor performs on behalf of the plan;
- To a spouse, family member, or other personal representative if they can show they are assisting in your care or payment of your care and then, without an authorization, only basic information about the status or payment of a claim.

Unless you give us written authorization, we cannot use or disclose your PHI for any reason except as otherwise described in this notice. You may revoke your written authorization at any time by writing us at the address indicated at the end of this notice.

III. Your Individual Rights

You have the following rights with regard to your Protected Health Information:

- **To Restrict our Use or Disclosure.** You have the right to ask us to limit our use or disclosure of your PHI. While we will consider your request, we are not legally required to agree to the additional restrictions. If we do agree to all or part of your request, we will inform you in writing. We cannot agree to limit any use and disclosure of your PHI if the use or disclosure is required by law.
- **To Access your PHI.** You have the right to view and/or copy your PHI at any time by contacting us. If you want copies of your PHI, or want your PHI in a special format, we may charge you a fee. You have a right to choose what portions of your PHI you want copied and to have prior notice of copying costs. If for some reason we deny your request for access to your PHI, we will provide a written explanation of why your request was denied and explain how you can appeal the denial.
- **To Amend your PHI.** You have the right to amend your PHI, if you believe it is incomplete or inaccurate. Your request must be in writing, with an explanation of why you feel the information should be amended. If we approve your request to amend your PHI, we will make reasonable efforts to inform others, including people you name, about the amendment to your PHI. We may deny your request for various reasons, for example, if we determine that the information is correct and complete, or if we did not create the information. If we deny your request, we will provide you a written explanation of our decision. We also will explain your rights regarding having your request and our response included with all future disclosures of your PHI.
- **To Obtain an Accounting of our Disclosures.** You have the right to receive a listing from us of all instances in which we or our business associates have disclosed your PHI for purposes other than treatment, payment, health care operations, or as authorized by you. This list will include only those disclosures made since April 14, 2003 and will only go back six years. The accounting will tell you the date we made the disclosure, the name of the person or entity to whom the disclosure was

made, a description of the PHI that was disclosed, and the reason for the disclosure. There may be a charge for accounting disclosures if requested more than once a year.

- **To Request Alternative Communications.** You have the right to ask us to communicate with you about your confidential information by a different method or at another location. We will accommodate all reasonable requests.
- **To Receive Notice.** You are entitled to receive a copy of this notice that outlines our HIPAA privacy practices. We reserve the right to change these practices and the terms of this notice at any time. We will not make any material changes to our privacy practices without first sending you a revised notice. If you receive this notice on our website or by electronic mail, you may request a paper copy.

IV. Who to Contact for Questions and Complaints

If you want more information about our privacy practices, wish to exercise any of your rights with regard to your PHI, or have any questions about the information in this notice, please use the contact information below. If you believe we may have violated your privacy rights, or if you disagree with a decision that we made in connection with your PHI, you may file a complaint using the contact information below. You may also submit a written complaint to the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may locate the regional office nearest to you by visiting their web site, <http://www.hhs.gov/ocr/privacyhowtofile.htm>. We fully support your right to the privacy of your PHI, and will not retaliate in any way if you choose to file a complaint.

Mailing Address:	Assurant Employee Benefits Privacy Office P.O. Box 419052 Kansas City, MO 64141-6052
Telephone:	800.733.7879
Email:	PrivacyOffice.AEB@assurant.com
Web Site:	www.assurantemployeebenefits.com

V. Organizations Covered by This Notice

This notice applies to the privacy practices of the organizations referenced below. These organizations may share your PHI with each other as needed for payment activities or health care operations relating to the dental or vision insurance that we provide.

VI. Effective Date of This Notice: April 14, 2003

*** In this notice, "we", "us", and "our" refer to Union Security Insurance Company and the following prepaid dental companies:** DentiCare of Alabama, Inc., Union Security DentalCare of Georgia, Inc., UDC Dental California, Inc., UDC Ohio, Inc., dba United Dental Care of Ohio, Inc., United Dental Care of Arizona, Inc., United Dental Care of Colorado, Inc., United Dental Care of Michigan, Inc., United Dental Care of Missouri, Inc., United Dental Care of New Mexico, Inc., United Dental Care of Texas, Inc., United Dental Care of Utah, Inc., Union Security DentalCare of New Jersey, Inc.

