

**UnitedHealthcare In Network Only Dental  
UnitedHealthcare Insurance Company  
Certificate of Coverage**

**FOR: City of Memphis**

**DENTAL PLAN NUMBER: PIN02**

**ENROLLING GROUP NUMBER: 706554**

**EFFECTIVE DATE: January 1, 2012**

**Offered and Underwritten by  
UnitedHealthcare Insurance Company**



# UnitedHealthcare Insurance Company

## Dental Certificate of Coverage

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

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

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

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

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

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

## Introduction to Your Certificate

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

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

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

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

## How To Use This Certificate

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

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

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

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

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

## Network Benefits

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

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

The exclusions and limitations that appear in the *Section 12: General Exclusions* apply to all benefits. The *Schedule of Covered Dental Services* or *Section 11: Covered Dental Services* describe what Copayments are required, if any, and to what extent limitations apply to each Covered Dental Service.

## **Dental Services Covered Under the Policy**

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

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

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

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

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

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

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

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

## **Important Note About Services**

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

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

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

- You are responsible for choosing your own Dentist.

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

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

## **Important Information Regarding Medicare**

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

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

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

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

## **Identification ("ID") Card**

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

## **Contact the Company**

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

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## Section 1: Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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



**Eligible Expenses** – Eligible Expenses for Covered Dental Services, incurred while the Policy is in effect, are the Company's contracted fee(s) for Covered Dental Services with that provider and any Usual and Customary fees for Orthodontic Dental Services.

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

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

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

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

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

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

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

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

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

**Maximum Policy Benefit** - the maximum amount paid during the entire period of time that the Covered Person is Covered under the Policy or any Policy, issued by the Company to the Enrolling Group, that replaces the Policy. The Maximum Policy Benefit is stated in *Section 11: Covered Dental Services*.

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

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

- A. necessary to meet the basic dental needs of the Covered Person; and
- B. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service; and
- C. consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; and
- D. consistent with the diagnosis of the condition; and

- E. required for reasons other than the convenience of the Covered Person or his or her Dentist; and
- F. demonstrated through prevailing peer-reviewed dental literature to be either:
  - 1. safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - 2. safe with promising efficacy
    - a. for treating a life threatening dental disease or condition; and
    - b. in a clinically controlled research setting; and
    - c. using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

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

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

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

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

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

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

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

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

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

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

**Rider** - any attached description of Dental Services Covered under the Policy. Dental Services provided by a Rider may be subject to payment of additional Premiums and additional Copayments. Riders are

effective only when signed by an officer of the Company and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended.

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

## **Section 2: Enrollment and Effective Date of Coverage**

### **Section 2.1 Enrollment**

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

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

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

### **Section 2.2 Effective Date of Coverage**

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

If an Eligible Person enrolls during the Initial Eligibility Period, Coverage is effective on the first day of the policy month following the month in which the probationary period was completed.

### **Section 2.3 Coverage for a Newly Eligible Person**

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

### **Section 2.4 Coverage for a Newly Eligible Dependent**

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

### **Section 2.5 Change in Family Status**

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

### **Section 2.6 Special Enrollment Period**

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

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

## **Section 3: Termination of Coverage**

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

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

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

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

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

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

### **Section 3.2 Extended Coverage for Handicapped Dependent Children**

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

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

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

### **Section 3.3 Extended Coverage**

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

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

### **Section 3.4 Payment and Reimbursement Upon Termination**

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

## Section 4: Reimbursement

### Section 4.1 Reimbursement of Eligible Expenses

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

### Section 4.2 Filing Claims for Reimbursement of Eligible Expenses

You are responsible for sending a request for reimbursement to the Company's office, on a form provided by or satisfactory to the Company. Requests for reimbursement should be submitted within 90 days after date of service. Unless you are legally incapacitated, failure to provide this information to the Company within 15 months of the date of service will cancel or reduce Coverage for the Dental Service.

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

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

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

**Proof of Loss.** Written proof of loss should be given to the Company within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 15 months after the date of service.

**Payment of Claims.** Benefits are payable in accordance with any state prompt pay requirements after the Company receives acceptable proof of loss.

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



### **Section 4.3 Limitation of Action for Reimbursement**

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

# **Section 5: Complaint Procedures**

## **Section 5.1 Complaint Resolution**

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

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

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

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

We will notify you of our decision regarding our reconsideration of your complaint within 30 days of receiving it. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

## **Section 5.2 Complaint Hearing**

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

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

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

## **Section 5.3 Exceptions for Emergency Situations**

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

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

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

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

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

## **Section 6: General Provisions**

### **Section 6.1 Entire Policy**

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

### **Section 6.2 Limitation of Action**

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

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

### **Section 6.3 Time Limit on Certain Defenses**

No statement, except a fraudulent statement, made by the Enrolling Group will be used to void the Policy after it has been in force for a period of 2 years. The Company will only void insurance if the fraud or misrepresentation is related to eligibility or the Enrolling Group was a participant in the fraud.

### **Section 6.4 Amendments and Alterations**

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

### **Section 6.5 Relationship Between Parties**

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

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

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

### **Section 6.6 Information and Records**

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

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

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

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

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

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

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

## **Section 6.7 Examination of Covered Persons**

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

## **Section 6.8 Clerical Error**

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

## **Section 6.9 Notice**

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

## **Section 6.10 Workers' Compensation Not Affected**

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

## **Section 6.11 Conformity with Statutes**

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

## **Section 6.12 Waiver/Estoppel**

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

## **Section 6.13 Headings**

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

## **Section 6.14 Unenforceable Provisions**

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

## Section 7: Coordination of Benefits

### Section 7.1 Coordination of Benefits Applicability

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

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

### Section 7.2 Definitions

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

- A. A "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
1. "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
  2. "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

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

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

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

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

2. If a person is covered by 2 or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
  3. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of Usual and Customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the primary Coverage Plan's payment arrangements will be the allowable expense for all Coverage Plans.
- D. "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.
- E. "Closed panel Coverage Plan" is a Coverage Plan that provides health or dental benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

### **Section 7.3 Order of Benefit Determination Rules**

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

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



- a. The primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
  - 1.) The parents are married;
  - 2.) The parents are not separated (whether or not they ever have been married); or
  - 3.) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

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

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

## **Section 7.4 Effect on the Benefits of This Coverage Plan**

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

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

- B. If a covered person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB will not apply between that Coverage Plan and other closed panel Coverage Plans.
- C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the primary Coverage Plan.

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

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

## **Section 7.5 Right to Receive and Release Needed Information**

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

## **Section 7.6 Payments Made**

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

## **Section 7.7 Right of Recovery**

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

## Section 8: Subrogation and Refund of Expenses

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

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

In exercising the Company's right of Subrogation, the Company will not attempt to recover from You unless You have been made whole by the responsible party.

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

- A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person,
- B. All or some of the payment made by the Company exceeded the benefits under the Policy, or
- C. All or some of the payment was made in error. The refund must be requested by the Company within 15 months from the date of the payment.

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

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

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

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

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

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

## **Section 9: Continuation of Coverage**

### **Section 9.1 Continuation Coverage**

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

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

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

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

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

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

### **Section 9.2 Continuation Coverage Under Federal Law**

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

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

### **Section 9.3 Qualifying Events for Continuation Coverage Under Federal Law**

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

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

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

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

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

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

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

## **Section 9.5 Terminating Events for Continuation Coverage Under Federal Law**

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

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

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

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

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

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

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



# Section 10: Procedures for Obtaining Benefits

## Section 10.1 Dental Services

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

### Network Benefits

Dental Services must be provided by a Network Dentist in order to be considered Network Benefits. 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 Dentist. 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 Dentist. You must submit appropriate reports and x-rays.

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

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

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

## Section 10.2 Pre-Treatment Estimate

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

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

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

## Section 11: Covered Dental Services

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

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

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

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

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

### **Network Benefits:**

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

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

### **Maximum Benefit**

**Maximum Benefit** is \$1,500 per Covered Person for Network Benefits per calendar year.

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

### **Maximum Policy Benefit**

**Maximum Policy Benefit** is \$1,000 per Covered Person for Network Benefits.

Maximum Policy Benefit applies to: ORTHODONTICS.

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

## **Section 11.1 CREDIT FOR PRIOR COVERAGE**

If you are a Covered Person that becomes Covered under this Policy due to a mid-year plan change 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).

## Section 12: General Exclusions

### Section 12.1 Exclusions

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

- A. Dental Services that are not Necessary.
- B. Hospitalization or other facility charges.
- C. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- D. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
- E. Any Dental Procedure not directly associated with dental disease.
- F. Any Dental Procedure not performed in a dental setting.
- G. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- H. Placement of dental implants, implant-supported abutments and prostheses.
- I. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- J. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- K. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- L. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
- M. Replacement of complete dentures, and fixed and removable partial dentures or crowns, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- N. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
- O. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

- P. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
- Q. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- R. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- S. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- T. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
- U. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- V. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
- W. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
- X. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- Y. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any 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.
- Z. Foreign Services are not Covered unless required as an Emergency.
- AA. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- BB. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.

## SCHEDULE OF COVERED DENTAL SERVICES

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT
		is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
<b>DIAGNOSTIC SERVICES</b>		
D0120	Periodic Oral Evaluation  Limited to 2 times per consecutive 12 months.	\$0
D0140	Limited Oral Evaluation - Problem Focused  Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service.	\$0
D0150	Comprehensive Oral Evaluation - new or established patient  Limited to 2 times per consecutive 12 months. Not Covered if done in conjunction with other exams.	\$0
D0160	Detailed and Extensive Oral Evaluation - Problem-Focused, by report  Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service.	\$0
D0170	Re-Evaluation, Limited, Problem Focused  Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service.	\$0
D0180	Comprehensive Periodontal Evaluation - new or established	\$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	patient  Limited to 2 times per consecutive 12 months.	
D0210	Intraoral - Complete Series (including bitewings)  Limited to 1 time per consecutive 36 months. Vertical bitewings can not be billed in conjunction with a complete series.	\$0
D0220	Intraoral - Periapical - First Film	\$0
D0230	Intraoral - Periapical - Each Additional Film	\$0
D0240	Intraoral Occlusal Film	\$0
D0250	Extraoral - First Film  Limited to 1 film per calendar year.	\$0
D0260	Extraoral - Each Additional Film  Limited to 1 film per calendar year.	\$0
D0270	Bitewing – Single Film  Limited to 4 films per calendar year.	\$0
D0272	Bitewings - Two Films  Limited to 1 series of films per calendar year.	\$0
D0274	Bitewings - Four Films  Limited to 1 series of films per calendar year.	\$0
D0277	Vertical Bitewings, 7-8 Films	\$0

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	Limited to 1 time per consecutive 36 months. Vertical bitewings can not be billed in conjunction with a complete series.	
D0330	Panoramic Film  Limited to 1 time per consecutive 36 months.	\$0
D0470	Diagnostic Casts  Limited to 1 time per consecutive 24 months.	\$0
<b>PREVENTIVE SERVICES</b>		
D1110	Prophylaxis – adult  Limited to 2 times per consecutive 12 months.	\$0
D1120	Prophylaxis – child  Limited to 2 times per consecutive 12 months.	\$0
D1201	Topical Application of Fluoride (Including Prophylaxis) - child  Limited to 2 times per consecutive 12 months.	\$0
D1203	Topical Application of Fluoride (Prophylaxis Not Included) – child  Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.	\$0
D1205	Topical Application of Fluoride (Including Prophylaxis) – adult  Limited to 2 times per	\$0



CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	consecutive 12 months.	
D1351	Sealant - Per Tooth  Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	\$0
<b>MINOR RESTORATIVE SERVICES</b>		
D1510	Space Maintainer - Fixed - Unilateral  Limited to Covered Persons under the age of 16 years, once per consecutive 60 months . Benefit includes all adjustment within 6 months of installation.	\$85
D1515	Space Maintainer - Fixed - Bilateral  Limited to Covered Persons under the age of 16 years, once per consecutive 60 months . Benefit includes all adjustment within 6 months of installation.	\$100
D1520	Space Maintainer - Removable - Unilateral  Limited to Covered Persons under the age of 16 years, once per consecutive 60 months . Benefit includes all adjustment within 6 months of installation.	\$105
D1525	Space Maintainer - Removable - Bilateral  Limited to Covered Persons under the age of 16 years,	\$163

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	once per consecutive 60 months . Benefit includes all adjustment within 6 months of installation.	
D1550	Recementation of Space Maintainer  Limited to 1 per consecutive 6 months after initial insertion.	\$12
D2140	Amalgam - One Surface, Primary or Permanent  Multiple restorations on one surface will be treated as a single filling.	\$30
D2150	Amalgam - Two Surfaces, Primary or Permanent  Multiple restorations on one surface will be treated as a single filling.	\$40
D2160	Amalgam - Three Surfaces, Primary or Permanent  Multiple restorations on one surface will be treated as a single filling.	\$45
D2161	Amalgam - Four or More Surfaces, Primary or Permanent  Multiple restorations on one surface will be treated as a single filling.	\$50
D2330	Resin-Based Composite - One Surface, Anterior  Multiple restorations on one surface will be treated as a single filling.	\$38

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
D2331	Resin-Based Composite - Two Surfaces, Anterior  Multiple restorations on one surface will be treated as a single filling.	\$47
D2332	Resin-Based Composite - Three Surfaces, Anterior  Multiple restorations on one surface will be treated as a single filling.	\$60
D2335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)  Multiple restorations on one surface will be treated as a single filling.	\$75
D2391	Resin-Based Composite - One Surface, Posterior  Multiple restorations on one surface will be treated as a single filling.	\$54
D2392	Resin-Based Composite - Two Surfaces, Posterior  Multiple restorations on one surface will be treated as a single filling.	\$73
D2393	Resin-Based Composite - Three Surfaces, Posterior  Multiple restorations on one surface will be treated as a single filling.	\$93
D2394	Resin-Based Composite - Four or More Surfaces, Posterior  Multiple restorations on one	\$111

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	surface will be treated as a single filling.	
D2410	Gold Foil - One Surface  Multiple restorations on one surface will be treated as a single filling. Covered on posterior teeth only.	\$130
D2420	Gold Foil - Two Surfaces  Multiple restorations on one surface will be treated as a single filling. Covered on posterior teeth only.	\$95
D2430	Gold Foil - Three Surfaces  Multiple restorations on one surface will be treated as a single filling. Covered on posterior teeth only.	\$167
<p><b>CROWNS/INLAYS/ONLAYS</b></p> <p>Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.</p>		
D2390	Resin-Based Composite Crown, Anterior  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.	\$59
D2510	Inlay - Metallic - One Surface  Limited to 1 time per tooth per consecutive 60 months.	\$310

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	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.	
D2520	Inlay - Metallic -Two Surfaces  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.	\$310
D2530	Inlay - Metallic - Three or More Surfaces  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.	\$310
D2542	Onlay - Metallic - Two Surfaces  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.	\$320
D2543	Onlay – Metallic - Three Surfaces  Limited to 1 time per tooth per consecutive 60 months.	\$320

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	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.	
D2544	Onlay – Metallic - Four or More Surfaces  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.	\$320
D2610	Inlay - Porcelain/Ceramic – One Surface  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.	\$313
D2620	Inlay - Porcelain/Ceramic - Two Surfaces  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.	\$313
D2630	Inlay - Porcelain/Ceramic - Three or More Surfaces	\$313

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	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.	
D2642	Onlay - Porcelain/Ceramic - Two Surfaces  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.	\$420
D2643	Onlay - Porcelain/Ceramic - Three Surfaces  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.	\$420
D2644	Onlay - Porcelain/Ceramic - Four or More Surfaces  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.	\$420

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
D2650	<p>Inlay - Composite/Resin - One Surface</p> <p>Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.</p>	\$320
D2651	<p>Inlay - Composite/Resin - Two Surfaces</p> <p>Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.</p>	\$320
D2652	<p>Inlay - Composite/Resin - Three Or More Surfaces</p> <p>Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.</p>	\$320
D2662	<p>Onlay - Composite/Resin - Two Surfaces</p> <p>Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and</p>	\$300



CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	core buildup codes.	
D2663	<p>Onlay - Composite/Resin - Three Surfaces</p> <p>Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.</p>	\$300
D2664	<p>Onlay - Composite/Resin - Four Or More Surfaces</p> <p>Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.</p>	\$300
D2710	<p>Crown - Resin-Based Composite (indirect)</p> <p>Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.</p>	\$101
D2712	<p>Crown - 3/4 Resin-Based Composite (indirect)</p> <p>Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction</p>	\$101

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	with any other inlay, onlay and crown codes except post and core buildup codes.	
D2720	Crown - Resin With High Noble Metal  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.	\$264
D2721	Crown - Resin With Predominantly Base Meta  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.	\$245
D2722	Crown - Resin With Noble Metal  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.	\$260
D2740	Crown - Porcelain/Ceramic Substrate  Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling	\$390

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	
D2750	Crown - Porcelain Fused To High Noble Metal  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.	\$380
D2751	Crown - Porcelain Fused To Predominantly Base Metal  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.	\$310
D2752	Crown - Porcelain Fused To Noble Metal  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.	\$370
D2780	Crown - 3/4 Cast High Noble Metal  Limited to 1 time per tooth per	\$380

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	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.	
D2781	Crown - 3/4 Cast Predominately Base Metal  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.	\$310
D2782	Crown - 3/4 Cast Noble Metal  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.	\$370
D2783	Crown - 3/4 Porcelain/Ceramic  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.	\$265
D2790	Crown - Full Cast High Noble Metal  Limited to 1 time per tooth per	\$380

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	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.	
D2791	Crown - Full Cast Predominantly Base Metal  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.	\$310
D2792	Crown - Full Cast Noble Metal  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.	\$370
D2794	Crown – titanium  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.	\$380
D2910	Recement Inlay, Onlay Or Partial Coverage Restoration  Limited to those performed	\$22

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	more than 12 months after the initial insertion.	
D2915	Recement Cast Or Prefabricated Post And Core  Limited to those performed more than 12 months after the initial insertion.	\$22
D2920	Recement Crown  Limited to those performed more than 12 months after the initial insertion.	\$25
D2930	Prefabricated Stainless Steel Crown - Primary Tooth  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.	\$70
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth  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.	\$70
D2932	Prefabricated Resin Crown  Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated	\$110

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	stainless steel crown - primary tooth, are limited to primary anterior teeth.	
D2933	<p>Prefabricated Stainless Steel Crown With Resin Window</p> <p>Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.</p> <p>Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.</p>	\$140
D2934	<p>Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth</p> <p>Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.</p> <p>Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.</p>	\$70
D2940	<p>Sedative Filling</p> <p>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.</p>	\$24
D2950	<p>Core Buildup, including any pins</p> <p>Covered only for teeth that have had root canal therapy.</p>	\$100
D2951	<p>Pin Retention - Per Tooth, in addition to Restoration</p> <p>Limited to 2 pins per tooth; not</p>	\$15

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	Covered in addition to cast restoration.	
D2952	Cast Post and Core in addition to Crown  Covered only for teeth that have had root canal therapy.	\$140
D2953	Each Additional Cast Post, Same Tooth  Covered only for teeth that have had root canal therapy.	\$42
D2954	Prefabricated Post and Core in addition to Crown  Covered only for teeth that have had root canal therapy.	\$100
D2957	Each Additional Prefabricated Post, Same Tooth  Covered only for teeth that have had root canal therapy.	\$49
D2980	Crown Repair, by report  Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	\$65
<b>ENDODONTICS</b>		
D3110	Pulp Cap - Direct (excluding final restoration)  Not covered if utilized solely as a liner or base underneath a restoration.	\$15
D3120	Pulp Cap - Indirect (excluding final Restoration)  Not covered if utilized solely as	\$18



CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	a liner or base underneath a restoration.	
D3220	Therapeutic Pulpotomy (excluding final restoration)  Limited to 1 time per primary or secondary tooth per lifetime.	\$50
D3221	Pulpal Debridement, Primary and Permanent Teeth  Limited to 1 time per tooth per lifetime. This procedure is not to be used when endodontic services are done on same date of service.	\$50
D3230	Pulpal Therapy (resorbable filling) - Anterior, Primary Tooth (excluding final restoration)  Limited to 1 per tooth per lifetime. Covered for anterior teeth only.	\$38
D3240	Pulpal Therapy (resorbable filling) - Posterior, Primary Tooth (excluding final restoration)  Limited to 1 per tooth per lifetime. Covered for posterior teeth only.	\$42
D3310	Root Canal Therapy - Anterior (excluding final restoration)  Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	\$157
D3320	Root Canal Therapy - Bicuspid (excluding final restoration)	\$212

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	
D3330	Root Canal Therapy - Molar (excluding final restoration)  Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	\$235
D3331	Treatment of Root Canal Obstruction, Non-Surgical Access  Limited to 1 time per tooth per lifetime.	\$80
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth  Limited to 1 time per tooth per lifetime.	\$95
D3333	Internal Root Repair of Perforation Defects  Limited to 1 time per tooth per lifetime.	\$75
D3346	Retreatment of Previous Root Canal Therapy - Anterior  Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	\$160

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
D3347	Retreatment of Previous Root Canal Therapy – Bicuspid  Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	\$195
D3348	Retreatment of Previous Root Canal Therapy – Molar  Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	\$280
D3351	Apexification/Recalcification - Initial Visit (apical closure/calcific repair of perforations, root resorption, etc.)  Limited to 1 time per tooth per lifetime.	\$120
D3352	Apexification/Recalcification - Interim Medication Replacement  Limited to 1 time per tooth per lifetime.	\$65
D3353	Apexification/Recalcification - Final Visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)  Limited to 1 time per tooth per lifetime.	\$173
D3410	Apicoectomy/Periradicular Surgery – Anterior	\$142

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	Limited to 1 time per tooth per lifetime.	
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (first root)  Limited to 1 time per tooth per lifetime.	\$155
D3425	Apicoectomy/Periradicular Surgery - Molar (first root)  Limited to 1 time per tooth per lifetime.	\$167
D3426	Apicoectomy/Periradicular Surgery (each additional root)  Limited to 1 time per tooth per lifetime.	\$70
D3430	Retrograde Filling - Per Root  Limited to 1 time per tooth per lifetime.	\$44
D3450	Root Amputation - Per Root  Limited to 1 time per tooth per lifetime.	\$180
D3920	Hemisection (including any root removal), not including Root Canal Therapy  Limited to 1 time per tooth per lifetime.	\$180
<b>PERIODONTICS</b>		
D4210	Gingivectomy or Gingivoplasty - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant  Limited to 1 per quadrant or site per consecutive 36	\$150

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	months.	
D4211	Gingivectomy or Gingivoplasty - One to Three Contiguous Teeth or Bounded Teeth Spaces Per Quadrant  Limited to 1 per quadrant or site per consecutive 36 months.	\$60
D4240	Gingival Flap Procedure, including Root Planing - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant  Limited to 1 per quadrant or site per consecutive 36 months.	\$135
D4241	Gingival Flap Procedure - One to Three Contiguous Teeth or Bounded Teeth Spaces Per Quadrant  Limited to 1 per quadrant or site per consecutive 36 months.	\$68
D4245	Apically Positioned Flap  Limited to 1 per quadrant or site per consecutive 36 months.	\$135
D4249	Clinical Crown Lengthening - Hard Tissue  Limited to 1 per quadrant or site per consecutive 36 months.	\$118
D4260	Osseous Surgery (including flap entry and closure) - Four or More Contiguous Teeth or Bounded Teeth Spaces Per	\$339

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	Quadrant  Limited to 1 per quadrant or site per consecutive 36 months.	
D4261	Osseous Surgery (including flap entry and closure) - One to Three Contiguous Teeth or Bounded Teeth Spaces Per Quadrant  Limited to 1 per quadrant or site per consecutive 36 months.	\$170
D4263	Bone Replacement Graft - First Site in Quadrant  Limited to 1 per quadrant or site per consecutive 36 months.	\$190
D4264	Bone Replacement Graft - each additional site in Quadrant  Limited to 1 per quadrant or site per consecutive 36 months.	\$100
D4265	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration  Limited to 1 per quadrant or site per consecutive 36 months.	\$95
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site  Limited to 1 per quadrant or site per consecutive 36 months.	\$240
D4267	Guided Tissue Regeneration -	\$290

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	Nonresorbable Barrier, Per Site  Limited to 1 per quadrant or site per consecutive 36 months.	
D4270	Pedicle Soft Tissue Graft Procedure  Limited to 1 per quadrant or site per consecutive 36 months.	\$210
D4271	Free Soft Tissue Graft Procedure (including donor site surgery)  Limited to 1 per quadrant or site per consecutive 36 months.	\$210
D4273	Subepithelial Connective Tissue Graft Procedures, Per Tooth  Limited to 1 per quadrant or site per consecutive 36 months.	\$340
D4274	Distal or Proximal Wedge Procedure (when not performed in conjunction with surgical procedures in the same anatomical area)  Limited to 1 per quadrant or site per consecutive 36 months.	\$130
D4275	Soft Tissue Allograft  Limited to 1 per quadrant or site per consecutive 36 months.	\$210
D4276	Combined Connective Tissue and Double Pedicle Graft, Per	\$340

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	Tooth  Limited to 1 per quadrant or site per consecutive 36 months.	
D4320	Provisional Splinting - Intracoronal  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 or bridges.  Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.	\$45
D4321	Provisional Splinting – Extracoronal  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 or bridges.  Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.	\$40
D4341	Periodontal Scaling and Root Planing - Four or More Teeth Per Quadrant  Limited to 1 time per quadrant per 24 consecutive months.	\$70
D4342	Periodontal Scaling and Root Planing - One - Three Teeth Per Quadrant	\$35



CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	Limited to 1 time per quadrant per 24 consecutive months.	
D4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis  Limited to once per consecutive 36 months.	\$60
D4910	Periodontal Maintenance  Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.	\$60
<p><b>REMOVABLE DENTURES</b></p> <p>Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.</p>		
D5110	Complete Denture – Maxillary  Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	\$440
D5120	Complete Denture – Mandibular  Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	\$440
D5130	Immediate Denture – Maxillary  Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	\$440

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
D5140	<p>Immediate Denture - Mandibular</p> <p>Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.</p>	\$440
D5211	<p>Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and teeth)</p> <p>Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.</p>	\$400
D5212	<p>Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth)</p> <p>Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.</p>	\$400
D5213	<p>Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)</p> <p>Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.</p>	\$440
D5214	<p>Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)</p> <p>Limited to 1 per consecutive 60</p>	\$440

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	months. No additional allowances for precision or semi-precision attachments.	
D5225	Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth)  Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	\$440
D5226	Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth)  Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	\$440
D5281	Removable Unilateral Partial Denture - One Piece Cast Metal (including clasps and teeth)  Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	\$200
D5410	Adjust Complete Denture – Maxillary  Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	\$19
D5411	Adjust Complete Denture - Mandibular  Limited to repairs or adjustments performed more than 12 months after the initial	\$19

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	insertion. Limited to 1 per consecutive 6 months.	
D5421	Adjust Partial Denture – Maxillary  Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	\$18
D5422	Adjust Partial Denture – Mandibular  Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	\$19
D5510	Repair Broken Complete Denture Base  Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	\$65
D5520	Replace Missing or Broken Teeth - Complete Denture (each tooth)  Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	\$60
D5610	Repair Resin Denture Base  Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per	\$65

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	consecutive 6 months.	
D5620	Repair Cast Framework  Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	\$75
D5630	Repair or Replace Broken Clasp  Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	\$75
D5640	Replace Broken Teeth - Per Tooth  Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	\$65
D5650	Add Tooth to Existing Partial Denture  Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	\$65
D5660	Add Clasp to Existing Partial Denture  Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	\$75
D5670	Replace All Teeth and Acrylic	\$240

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	<p>on Cast Metal Framework (Maxillary)</p> <p>Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.</p>	
D5671	<p>Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular)</p> <p>Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.</p>	\$240
D5710	<p>Rebase Complete Maxillary Denture</p> <p>Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.</p>	\$150
D5711	<p>Rebase Complete Mandibular Denture</p> <p>Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.</p>	\$150
D5720	<p>Rebase Maxillary Partial Denture]</p> <p>Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.</p>	\$150

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
D5721	Rebase Mandibular Partial Denture  Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	\$150
D5730	Reline Complete Maxillary Denture (Chairside)  Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	\$100
D5731	Reline Complete Mandibular Denture (Chairside)  Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	\$100
D5740	Reline Maxillary Partial Denture (Chairside)  Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	\$100
D5741	Reline Mandibular Partial Denture (Chairside)  Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	\$100
D5750	Reline Complete Maxillary	\$150

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	Denture (Laboratory)  Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	
D5751	Reline Complete Mandibular Denture (Laboratory)  Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	\$150
D5760	Reline Maxillary Partial Denture (Laboratory)  Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	\$150
D5761	Reline Mandibular Partial Denture (Laboratory)  Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	\$150
D5810	Interim Complete Denture (Maxillary)  Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	\$205
D5811	Interim Complete Denture (Mandibular)  Limited to 1 per consecutive 60	\$205



CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	months. No additional allowances for precision or semi-precision attachments.	
D5820	Interim Partial Denture (Maxillary)  Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	\$165
D5821	Interim Partial Denture (Mandibular)  Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	\$165
<p><b>BRIDGES (fixed partial dentures)</b></p> <p>Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.</p>		
D6205	Pontic - Indirect Resin Based Composite  Limited to 1 time per tooth per consecutive 60 months.	\$101
D6210	Pontic - Cast High Noble Metal  Limited to 1 time per tooth per consecutive 60 months.	\$380
D6211	Pontic - Cast Predominantly Base Metal  Limited to 1 time per tooth per consecutive 60 months.	\$310
D6212	Pontic - Cast Noble Metal  Limited to 1 time per tooth per	\$370

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	consecutive 60 months.	
D6214	Pontic – Titanium  Limited to 1 time per tooth per consecutive 60 months.	\$380
D6240	Pontic - Porcelain Fused to High Noble Metal  Limited to 1 time per tooth per consecutive 60 months.	\$380
D6241	Pontic - Porcelain Fused to Predominantly Base Metal  Limited to 1 time per tooth per consecutive 60 months.	\$310
D6242	Pontic - Porcelain Fused to Noble Metal  Limited to 1 time per tooth per consecutive 60 months.	\$370
D6245	Pontic - Porcelain/Ceramic  Limited to 1 time per tooth per consecutive 60 months.	\$390
D6710	Crown - Indirect Resin Based Composite (not to be used as a temporary or provisional prosthesis)  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.	\$101
D6720	Crown - Resin with High Noble Metal  Limited to 1 time per tooth per consecutive 60 months. Not Covered if done in conjunction	\$264

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	with any other inlay, onlay and crown codes except post and core buildup codes.	
D6721	Crown - Resin with Predominantly Base Metal  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.	\$245
D6722	Crown - Resin with Noble Metal  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.	\$260
D6740	Crown - Porcelain/Ceramic  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.	\$390
D6750	Crown - Porcelain Fused to High Noble Metal  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.	\$380
D6751	Crown - Porcelain Fused to Predominantly Base Metal  Limited to 1 time per tooth per	\$310

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	consecutive 60 months. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	
D6752	Crown - Porcelain Fused to Noble Metal  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.	\$370
D6780	Crown - 3/4 Cast High Noble Metal  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.	\$380
D6781	Crown - 3/4 Cast Predominately Based Metal  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.	\$310
D6782	Crown - 3/4 Cast Noble Metal  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.	\$370
D6783	Crown - 3/4 Porcelain/Ceramic	\$265

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	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.	
D6790	Crown - Full Cast High Noble Metal  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.	\$380
D6791	Crown - Full Cast Predominantly Base Metal  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.	\$310
D6792	Crown - Full Cast Noble Metal  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.	\$370
D6794	Crown – Titanium  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.	\$380
D6930	Recement Fixed Partial	\$30

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	Denture  Limited to those performed more than 12 months after the initial insertion.	
D6970	Cast Post and Core in addition to Fixed Partial Denture Retainer  Covered only for teeth that have had root canal therapy.	\$85
D6971	Cast Post as part of Fixed Partial Denture Retainer  Covered only for teeth that have had root canal therapy.	\$76
D6972	Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer  Covered only for teeth that have had root canal therapy.	\$113
D6973	Core Build Up for Retainer, including any Pins  Covered only for teeth that have had root canal therapy.	\$58
D6976	Each Additional Cast Post - Same Tooth  Covered only for teeth that have had root canal therapy.	\$33
D6977	Each Additional Prefabricated Post - Same Tooth  Covered only for teeth that have had root canal therapy.	\$32
<b>ORAL SURGERY</b>		
D7111	Extraction, Coronal Remnants - Deciduous Tooth	\$15

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	Limited to 1 time per tooth per lifetime.	
D7140	Extraction, Erupted Tooth or Exposed Root (elevation and/or forceps removal)  Limited to 1 time per tooth per lifetime.	\$30
D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth  Limited to 1 time per tooth per lifetime.	\$70
D7220	Removal of Impacted Tooth - Soft Tissue  Limited to 1 time per tooth per lifetime.	\$90
D7230	Removal of Impacted Tooth - Partially Bony  Limited to 1 time per tooth per lifetime.	\$109
D7240	Removal of Impacted Tooth - Completely Bony  Limited to 1 time per tooth per lifetime.	\$145
D7241	Removal of Impacted Tooth - Completely Bony, With Unusual Surgical  Limited to 1 time per tooth per lifetime.	\$130
D7250	Surgical Removal of Residual Tooth Roots (cutting procedure)	\$65

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	Limited to 1 time per tooth per lifetime.	
D7260	Oroantral Fistula Closure  Limited to 1 per tooth per lifetime.	\$168
D7261	Primary Closure of a Sinus Perforation  Limited to 1 per tooth per lifetime.	\$168
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth  Limited to 1 per site per lifetime.	\$94
D7280	Surgical Access of an Unerupted Tooth  Limited to 1 time per tooth per lifetime.	\$121
D7282	Mobilization of Erupted or Malpositioned Tooth to aid Eruption  Limited to 1 time per tooth per lifetime.	\$90
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth  Limited to 1 time per tooth per lifetime.	\$61
D7285	Biopsy of Oral Tissue - Hard (bone, tooth)  Limited to 1 biopsy per site per visit.	\$83



CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
D7286	Biopsy of Oral Tissue - Soft (all others)  Limited to 1 biopsy per site per visit.	\$80
D7287	Exfoliative Cytological Sample Collection  Limited to 1 biopsy per site per visit.	\$40
D7288	Brush Biopsy - Transepithelial Sample Collection  Limited to 1 biopsy per site per visit.	\$40
D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report  Limited to 1 time per tooth per lifetime.	\$27
D7310	Alveoplasty In Conjunction With Extractions - Per Quadrant	\$49
D7311	Alveoplasty In Conjunction With Extraction - One to Three Teeth or Tooth Spaces, Per Quadrant	\$25
D7320	Alveoplasty Not In Conjunction With Extractions - Per Quadrant	\$84
D7321	Alveoplasty Not In Conjunction With Extraction - One to Three Teeth or Tooth Spaces, Per Quadrant.	\$42
D7450	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter up to 1.25 cm  Limited to 1 per site per visit.	\$92

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
D7451	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter greater than 1.25 cm  Limited to 1 per site per visit.	\$162
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue  Limited to 1 per site per visit.	\$36
D7511	Incision and Drainage of Abscess - Intraoral Soft Tissue - Complicated (includes drainage of multiple fascial spaces)  Limited to 1 per site per visit.	\$45
D7960	Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure	\$92
D7963	Frenuloplasty	\$92
D7970	Excision of Hyperplastic Tissue - Per Arch  Limited to 1 per site per consecutive 36 months.	\$150
D7971	Excision of Pericoronal Gingival  Limited to 1 per site per consecutive 36 months.	\$65
D7972	Surgical Reduction of Fibrous Tuberosity  Limited to 1 per site per consecutive 36 months.	\$150
<b>ADJUNCTIVE SERVICES</b>		
D9110	Palliative (Emergency) Treatment of Dental Pain -	\$35

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	<p>Minor Procedure</p> <p>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.</p>	
D9210	<p>Local Anesthesia not in conjunction with Operative or Surgical Procedures</p> <p>Limited to 1 charge per visit.</p>	\$6
D9220	<p>Deep Sedation/General Anesthesia - First 30 Minutes</p> <p>Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.</p>	\$115
D9221	<p>Deep Sedation/General Anesthesia - Each Additional 15 Minutes</p> <p>Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.</p>	\$60
D9230	<p>Analgesia Anxiolysis, Inhalation of Nitrous Oxide</p> <p>Covered when Necessary in</p>	\$10

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	
D9241	<p>Intravenous Conscious Sedation/Analgesia - First 30 Minutes</p> <p>Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.</p>	\$115
D9242	<p>Intravenous Conscious Sedation/Analgesia - Each Additional 15 Minutes</p> <p>Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.</p>	\$55
D9248	<p>Non-Intravenous Conscious Sedation</p> <p>Covered when Necessary in conjunction with Covered Dental Services. If required for</p>	\$28

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT  is shown as a percentage of Eligible Expenses or is shown as a fixed dollar amount after any applicable Deductible is satisfied.
	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.	
D9310	Consultation (diagnostic service provided by Dentist or Physician other than practitioner providing treatment)  Not Covered if done with exams or professional visit.	\$22
D9630	Other Drugs and/or Medicaments, by report  Limited to 1 per visit.	\$7
D9910	Application of Desensitizing Medicament	\$9
D9940	Occlusal Guard, by report  Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.	\$175
D9942	Repair and/or Reline of Occlusal Guards  Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	\$53
D9951	Occlusal Adjustment - Limited	\$45
D9952	Occlusal Adjustment – Complete	\$110

CDT CODE	BENEFIT DESCRIPTION AND LIMITATION	NETWORK COPAYMENT	NON-NETWORK COPAYMENT
		is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.	is shown as a percentage of Eligible Expenses or is shown as a fixed dollar after applicable Deductible is satisfied.  You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
<b>ORTHODONTICS</b>			
D8010-D8090 and D8660-D8691	Orthodontic Services  Services or supplies furnished by a Dentist to a Covered Person 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%
D8210 D8220	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%
D0340	Cephalometric Film  Limited to 1 per consecutive 12 months. Can only be billed for orthodontics.	50%	50%

# Dependent Coverage Amendment

## UnitedHealthcare Insurance Company

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

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

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

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

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

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

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

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

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

# **UNITEDHEALTHCARE DENTAL**

## **NOTICE OF PRIVACY PRACTICES**

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

**Effective: April 14, 2003**

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

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

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

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



## How We Use or Disclose Information

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

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

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

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

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

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers compensation laws of job-related injuries.

- **Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

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

## Highly Confidential Information

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

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

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

## What Are Your Rights

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

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. box instead of your home address).
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.

- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, [www.uhcspecialtybenefits.com](http://www.uhcspecialtybenefits.com)

### **Exercising Your Rights**

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

United Healthcare  
Customer Service - Privacy Unit  
PO Box 740815  
Atlanta, GA 30374-0815

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

## Financial Information Privacy Notice

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

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

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

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

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

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

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

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

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

## **Continuation Coverage under Federal Law (COBRA)**

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

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

- A subscriber.
- A subscriber's enrolled dependent, including with respect to the subscriber's children, a child born to or placed for adoption with the subscriber during a period of continuation coverage under federal law.
- A subscriber's former spouse.

## **Qualifying Events for Continuation Coverage under Federal Law (COBRA)**

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

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

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

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

- A. Termination of the subscriber from employment with the enrolling group, for any reason other than the subscriber's gross misconduct.
- B. Reduction in the subscriber's hours of employment.
- C. Death of the subscriber.
- D. Divorce or legal separation of the subscriber.
- E. Loss of eligibility by an enrolled dependent who is a child.
- F. Entitlement of the subscriber to Medicare benefits.
- G. The enrolling group filing for bankruptcy, under Title 11, United States Code. This is also a qualifying event for any retired subscriber and his or her enrolled dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

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

### **Notification Requirements for Qualifying Event**

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

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

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

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

### **Notification Requirements for Disability Determination or Change in Disability Status**

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

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

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

After providing notice to the enrolling group's plan administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the plan administrator.

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

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



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

## **Terminating Events for Continuation Coverage under Federal Law (COBRA)**

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

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

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

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

Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

- B. Thirty-six months from the date of the qualifying event for an enrolled dependent whose coverage ended because of the death of the subscriber, divorce or legal separation of the subscriber, or loss of eligibility by an enrolled dependent who is a child (i.e. qualifying events C., D., or E.).
- C. With respect to Qualified Beneficiaries, and to the extent that the subscriber was entitled to Medicare prior to the qualifying event:
- Eighteen months from the date of the subscriber's Medicare entitlement; or
  - Thirty-six months from the date of the subscriber's Medicare entitlement, if a second qualifying event (that was due to either the subscriber's termination of employment or the subscriber's work hours being reduced) occurs prior to the expiration of the eighteen months.
- D. With respect to Qualified Beneficiaries, and to the extent that the subscriber became entitled to Medicare subsequent to the qualifying event:

- Thirty-six months from the date of the subscriber's termination from employment or work hours being reduced (first qualifying event) if:
  - The subscriber's Medicare entitlement occurs within the eighteen month continuation period; and
  - If, absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.
- E. The date coverage terminates under the policy for failure to make timely payment of the premium.
- F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
- G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the enrolling group filed for bankruptcy, (i.e. qualifying event G.). If the Qualified Beneficiary was entitled to continuation because the enrolling group filed for bankruptcy, (i.e. qualifying event G.) and the retired subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the subscriber's death.
- H. The date the entire policy ends.
- I. The date coverage would otherwise terminate under the policy.



