SUMMARY PLAN DESCRIPTION

AI Fire, LLC

Dental PPO Plan

Dental Plan Code: 86H81

Effective: January 1, 2025

Group Number: 914401

UnitedHealthcare®

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Summary Plan Description

United Healthcare Services, Inc.

What Is the Summary Plan Description?

This *Summary Plan Description (SPD)* is a summary of the Covered Dental Care Services available to you under the AI Fire, LLC ("Plan Sponsor") Self-Funded dental benefit plan. This SPD is a legal document that describes Benefits for the portion of the Plan for which United Healthcare Services, Inc.("Claims Administrator") administers claims payment, either directly or in conjunction with one of the Claims Administrator's affiliates. The *SPD* describes Covered Dental Care Services, subject to the terms, conditions, exclusions and limitations of the Plan

For the purposes of this provision "Self-Funded" means that the Plan Sponsor, on behalf of the Plan, has the sole responsibility to pay, and provide funds, to pay for all Plan benefits. The Claims Administrator has no liability or responsibility to provide these funds. The Claims Administrator is a private healthcare claims administrator. The Claims Administrator is not the Plan Administrator for the Plan. Although the Claims Administrator will assist you in many ways, it does not guarantee any Benefits. The Plan Sponsor is solely responsible for the benefit plan design and funding payment of Benefits.

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

- The *Schedule of Covered Dental Care Services*.
- Amendments.
- Addendums.
- *Summary Material Modification (SMM)*.

If there should be an inconsistency between the contents of this summary and the Plan, your rights shall be determined under the Plan and not under this summary. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of the official plan document by written request to the Plan Administrator, for a nominal charge.

Can This Certificate Change?

The Plan Sponsor may, from time to time, change this *SPD* by attaching legal documents called SMMs and/or Amendments that may change certain provisions of this *SPD*. When this happens the Plan Sponsor will send you a new *SPD*, Amendment, Addendums or *SMMs*.

Other Information You Should Have

The Plan Sponsor intends to continue this Plan, but reserves the right, in its sole discretion, to change, interpret, withdraw or add Benefits, or to end the Plan, as permitted by law, without your approval, subject to any collective bargaining agreements, if applicable.

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

The Plan will take effect on the date shown in the Plan. Coverage under the Plan starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Plan Sponsor's location.

The Plan is governed by ERISA unless the Plan Sponsor is not a private plan sponsor.

Introduction to Your SPD

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

What Are Defined Terms?

Certain capitalized words have special meanings. The Plan Sponsor has defined these words in *Section 9: Defined Terms.*

When the Plan Sponsor uses the words "you" and "your," the Plan Sponsor is referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms.*

How Do You Use This Document?

Read your entire *SPD* and any attached Amendments, Addendums or *SMMs*. You may not have all of the information you need by reading just one section. Keep your *SPD* and *Schedule of Covered Dental Care Services* and any attachments in a safe place for your future reference. You can also get this SPD at www.myuhc.com.

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

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

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

How Do You Contact the Claims Administrator?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact the Claims Administrator for more information.

Your Responsibilities

Enrollment and Required Contributions

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

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

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

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

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

Decide What Services You Should Receive

Care decisions are between you and your Dental Provider. The Claims Administrator and the Plan Sponsor do not make decisions about the kind of care you should or should not receive.

Choose Your Dental Provider

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

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

You should show your ID card every time you request dental care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered,

File Claims with Complete and Accurate Information

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

Claims Administrator and Plan Sponsor Responsibilities

Determine Benefits

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

The Plan Sponsor and the Claims Administrator have the discretion to do the following:

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

The Plan Sponsor and the Claims Administrator may assign this discretionary authority to other persons or entities including the Claims Administrator’s affiliates that may provide administrative services for the Plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in the Plan Sponsor and the Claims Administrator discretion. In order to receive Benefits, you must cooperate with those service providers.

Process Payment for the Plan's Portion of the Cost of Covered Dental Care Services

The Claims Administrator processes the Plan's payment Benefits for Covered Dental Care Services as described in *Section 1: Covered Dental Care Services* and in the *Schedule of Covered Dental Care Services*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means the Claims Administrator processes only the payment of the Plan's portion of the cost of Covered Dental Care Services. It also means that not all of the dental care services you receive may be paid for (in full or in part) by the Plan.

Process Plan Payment to Network Dental Providers

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

Process Plan Payment for Covered Dental Care Services Provided by Out-of-Network Dental Providers

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

Review and Determine Benefits in Accordance with the Claims Administrator's Reimbursement Policies

The Claims Administrator develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), the Claims Administrator's reimbursement policies are applied to provider billings. The Claims Administrator shares its reimbursement policies with Physicians and other providers in the Claims Administrator's Network through the Claims Administrator's provider website. Network Dental Providers may not bill you for the difference between their contract rate (as may be modified by the Claims Administrator's reimbursement policies) and the billed charge. However, out-of-Network dental providers may bill you for any amounts the Plan does not pay, including amounts that are denied because one of the Claims Administrator's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Dental Provider or provider by contacting the Claims Administrator at www.myuhc.com or by calling the Claims Administrator at the telephone number on your ID card.

UnitedHealthcare Dental PPO

United Healthcare Services, Inc.

Schedule of Covered Dental Care Services

How Do You Access Benefits?

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

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

Network Dental Providers

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

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

Directory of Network Dental Providers

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

Network and out-of-Network Benefits

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

Network Benefits

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

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

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

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

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

Network Dental Providers. You are responsible for verifying the Network participation status of your Dental Provider, prior to receiving such Dental Care Services.

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

Coverage for Dental Care Services is subject to payment of the Premium required for Coverage under the Policy, satisfaction of any applicable deductible, and payment of the Co-insurance specified for any service shown in this Schedule of Covered Dental Care Services and generally require you to pay less to the Dental Provider than out-of-Network Benefits. Network Benefits are determined based on the contracted fee for each Covered Dental Care Service. In no event will you be required to pay a Network Dental Provider an amount for a Covered Dental Care Service in excess of the contracted fee.

Network Benefits:

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

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

Out-of-Network Benefits

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

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

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

Classes of Dental Benefits

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

Class I - Dental Benefits:

- Diagnostic Services
- Preventive Services
- Radiographs
- Space Maintainers

Class II - Dental Benefits:

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

Class III - Dental Benefits:

- Minor Restorative Services
- Major Restorative Services
- Prosthodontic Services
- Removable Dentures

Class IV - Dental Benefits:

- Orthodontic Services

When Co-insurance is charged as a percentage of Usual and Customary fees, the amount you pay for Dental Care Services from out-of-Network Dental Providers is determined as a percentage of the Usual and Customary fee plus the amount by which the out-of-Network Dental Provider's billed charge exceeds the Usual and Customary fee.

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

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Cone Beam CT Capture and Interpretation with Field of View of Both Jaws, With and Without Cranium Limited to 1 time every consecutive 60 months.	50%	50%
Cone Beam CT Image Capture for TMJ Series Including Two or More Exposures Limited to 1 time every consecutive 60 months.	50%	50%
Diagnostic Casts Limited to 1 time per consecutive 24 months.	0%	0%
Extraoral Radiographs Images Limited to 2 images per.	0%	0%
Intraoral - Complete Series of Radiograph Images Limited to 1 time per consecutive 36 months. Vertical bitewings can not be billed in conjunction with a complete series.	0%	0%
Intraoral Periapical Radiographs Image Limited to 8 images per calendar year.	0%	0%
Pulp Vitality Tests Limited to 1 charge per visit, regardless of how many teeth are tested.	0%	0%

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Intraoral Occlusal Radiographs Image Limited to 2 images per consecutive 6 months.	0%	0%
Vertical Bitewings, 7-8 Radiograph Images Limited to 1 series of images per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series.	0%	0%
Periodic Oral Evaluation Limited to 2 times per consecutive 12 months.	0%	0%
Comprehensive Oral Evaluation Limited to new patients or 2 times per consecutive 12 months. Not covered if done in conjunction with other exams.	0%	0%
Limited or Detailed Oral Evaluation Limited to 2 times per consecutive 12 months. Only 1 exam is covered per date of service.	0%	0%
Comprehensive Periodontal Evaluation - new or established patient Limited to 2 times per consecutive 12 months.	0%	0%

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Oral Evaluation for a Patient under three Years of Age and Counseling Primary Caregiver Limited to 2 times per consecutive 12 months. Not covered if done in conjunction with other exams.	0%	0%
Teledentistry - synchronous; real-time encounter Limited to 2 times per consecutive 12 months.	0%	0%
Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review Limited to 2 times per consecutive 12 months.	0%	0%
Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures Limited to 1 time per consecutive 12 months.	0%	0%
CLASS I **PREVENTIVE SERVICES**		
Dental Prophylaxis Limited to 2 times per consecutive 12 months.	0%	0%
Fluoride Treatments - child Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.	0%	0%

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Sealants Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	0%	0%
Preventive Resin Restoration in a Moderate to High Caries Risk Patient - Permanent Tooth Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	0%	0%
CLASS I SPACE MAINTAINERS		
Space Maintainers Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	0%	0%
Re-Cementation of Space Maintainers Limited to 1 per consecutive 6 months after initial insertion.	0%	0%
Removal of Fixed Space Maintainer	0%	0%
CLASS II MINOR RESTORATIVE SERVICES		
Amalgam Restorations Multiple restorations on one surface will be treated as a single filling.	20%	20%

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Composite Resin Restorations - Anterior Multiple restorations on one surface will be treated as a single filling.	20%	20%
Gold Foil Restorations Multiple restorations on one surface will be treated as a single filling.	20%	20%
CLASS II ENDODONTICS		
Apexification Limited to 1 time per tooth per lifetime.	20%	20%
Apicoectomy Limited to 1 time per tooth per lifetime.	20%	20%
Retrograde Filling Limited to 1 time per tooth per lifetime.	20%	20%
Hemisection Limited to 1 time per tooth per lifetime.	20%	20%
Root Canal Therapy Limited to 1 time per tooth per lifetime. Dentist cannot charge retreatment codes on tooth treated for the first 12 months.	20%	20%

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Retreatment of Previous Root Canal Therapy Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	20%	20%
Root Resection/Amputation Limited to 1 time per tooth per lifetime.	20%	20%
Therapeutic Pulpotomy Limited to 1 time per primary or secondary tooth per lifetime.	20%	20%
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration) Limited to 1 per tooth per lifetime. Covered for anterior or posterior teeth only.	20%	20%
Pulp Caps - Direct/Indirect - excluding final restoration Not covered if utilized solely as a liner or base underneath a restoration.	20%	20%
Pulpal Debridement, Primary and Permanent Teeth Limited to 1 time per tooth per lifetime. Not covered on the same day as other endodontic services.	20%	20%

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Pulpal Regeneration - (Completion of Regenerative Treatment in an Immature Permanent Tooth with a Necrotic Pulp) does not include Final Restoration Limit 1 per tooth per lifetime.	20%	20%
CLASS II PERIODONTICS		
Crown Lengthening Limited to 1 per quadrant or site per consecutive 36 months.	20%	20%
Gingivectomy/Gingivoplasty Limited to 1 per quadrant or site per consecutive 36 months.	20%	20%
Gingival Flap Procedure Limited to 1 per quadrant or site per consecutive 36 months.	20%	20%
Osseous Graft Limited to 1 per quadrant or site per consecutive 36 months.	20%	20%
Osseous Surgery Limited to 1 per quadrant or site per consecutive 36 months.	20%	20%
Guided Tissue Regeneration Limited to 1 per quadrant or site per consecutive 36 months.	20%	20%
Soft Tissue Surgery Limited to 1 per quadrant or site per consecutive 36 months.	20%	20%

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Surgical Revision Procedure Limited to 1 per quadrant per consecutive 36 months.	20%	20%
Periodontal Maintenance Is Covered in combination with dental prophylaxis but not on same date of service, benefit is not to exceed in combination with dental prophylaxis 4 per consecutive 12 months.	20%	20%
Full Mouth Debridement Limited to once per consecutive 36 months.	20%	20%
Provisional Splinting Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.	20%	20%
Scaling and Root Planing Limited to 1 time per quadrant per consecutive 24 months. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - Limited to 2 times per consecutive 12 months.	20%	20%

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Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report Limited to 3 sites per quadrant or 12 sites total for refractory pockets or in conjunction with Periodontal Scaling and Root Planing	20%	20%
CLASS II ORAL SURGERY		
Alveoloplasty	20%	20%
Biopsy Limited to 1 biopsy per site per visit.	20%	20%
Frenectomy/Frenuloplasty	20%	20%
Surgical Incision Limited to 1 per site per visit.	20%	20%
Removal of a Benign Cyst/Lesions Limited to 1 per site per visit.	20%	20%
Removal of Torus Limited to 1 per site per visit.	20%	20%
Root Removal, Surgical Limited to 1 time per tooth per lifetime.	20%	20%
Simple Extractions Limited to 1 time per tooth per lifetime.	20%	20%

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Surgical Extraction of Erupted Teeth or Roots Limited to 1 time per tooth per lifetime.	20%	20%
Surgical Extraction of Impacted Teeth Limited to 1 per tooth per lifetime.	20%	20%
Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth Limited to 1 per tooth per lifetime.	20%	20%
Primary Closure of a Sinus Perforation Limited to 1 per tooth per lifetime.	20%	20%
Placement of Device to Facilitate Eruption of Impacted Tooth Limited to 1 time per tooth per lifetime.	20%	20%
Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report Limited to 1 time per tooth per lifetime.	20%	20%
Vestibuloplasty Limited to 1 time per site per consecutive 60 months.	20%	20%

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Bone Replacement Graft for Ridge Preservation - per site Limited to 1 per site per lifetime. Not covered if done in conjunction with other bone graft replacement procedures.	20%	20%
Excision of Hyperplastic Tissue or Pericoronal Gingiva Limited to 1 per site per consecutive 36 months.	20%	20%
Appliance Removal (not by dentist who placed appliance) includes removal of arch bar Limited to once per appliance per lifetime.	20%	20%
Tooth Reimplantation and/or Transplantation Services Limited to 1 per site per lifetime.	20%	20%
CLASS II ADJUNCTIVE SERVICES		
Analgesia Covered when Necessary in conjunction with Covered Dental Care Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	20%	20%
Desensitizing Medicament	20%	20%

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General Anesthesia Covered when Necessary in conjunction with Covered Dental Care Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	20%	20%
Local Anesthesia Not Covered in conjunction with operative or surgical procedure.	20%	20%
Intravenous Sedation and Analgesia Covered when Necessary in conjunction with Covered Dental Care Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	20%	20%
Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report	20%	20%
Occlusal Adjustment	20%	20%
Occlusal Guards Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.	20%	20%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Occlusal Guard Reline and Repair Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	20%	20%
Occlusion Analysis - Mounted Case Limited to 1 time per consecutive 60 months.	20%	20%
Emergency Palliative Treatment Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.	20%	20%
Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.) Not covered if done with exams or professional visit.	20%	20%
CLASS III **MAJOR RESTORATIVE SERVICES** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Coping Limited to 1 per tooth per consecutive 60 months. Not covered if done at the same time as a crown on same tooth.	50%	50%

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

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Inlays/Onlays - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%	50%
Pontics Limited to 1 time per tooth per consecutive 60 months.	50%	50%
Retainer-Cast Metal for Resin Bonded Fixed Prosthesis Limited to 1 time per consecutive 60 months.	50%	50%
Pin Retention Limited to 2 pins per tooth; not Covered in addition to cast restoration. Cast Restoration is defined as inlays and onlays Limited to 1 time per consecutive 60 months.	50%	50%
Post and Cores Covered only for teeth that have had root canal therapy.	50%	50%
Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core Limited to 1 per consecutive 12 months. Limited to those performed more than 12 months after the initial insertion.	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Protective Restoration Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.	50%	50%
Stainless Steel Crowns Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	50%	50%
CLASS III **FIXED PROSTHETICS** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Fixed Partial Dentures (bridges) Limited to 1 time per tooth per consecutive 60 months.	50%	50%
CLASS III **REMOVABLE PROSTHETICS** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Full Dentures Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	50%	50%

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
Partial Dentures Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	50%	50%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	50%	50%
Tissue Conditioning - Maxillary or Mandibular Limited to 1 time per consecutive 12 months.	50%	50%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	50%	50%
CLASS IV ORTHODONTICS Orthodontic services are subject to the applicable Waiting Period, satisfaction of any Deductible and any orthodontic Deductible, and payment of any applicable Copayments. Benefits will be paid in monthly installments on a schedule determined by the Enrolling Group over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.		

BENEFIT DESCRIPTION & LIMITATION	NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied.	OUT-OF-NETWORK CO-INSURANCE Is shown as a percentage of Allowed Amounts after applicable Deductible is satisfied. You must also pay the amount of the Dental Provider's fee, if any, which is greater than the Allowed Amount.
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%
Appliance Therapy, Fixed or Removable Limited to 1 time per consecutive 60 months. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.	50%	50%
Cephalometric Radiographic Image Limited to 1 per consecutive 12 months. Can only be billed for orthodontics.	50%	50%

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

Cost Share: Deductibles and Benefit Maximums

Deductible

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

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

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

Maximum Benefit is $2,000 per Covered Person for Network Benefits and $2,000 per Covered Person for out-of-Network Benefits per.

The sum of all Network Benefits and out-of-Network Benefits will not exceed $2000 per Covered Person per calendar year.

Consumer Max Multiplier

If a Covered Person has claims for Covered Dental Care Services in a of less than $1,000 an additional $500 will be added to the Maximum Benefit in the next calendar year up to a limit of $1,500 additional Maximum Benefit.

After the first following the Covered Person's Effective Date, the Maximum Benefit per Covered Person may be increased by the carry over amount if:

a.) the Covered Person has submitted a claim for an Allowed Amount incurred during the preceding; and

b.) the reimbursement for the Allowed Amount incurred in the preceding calendar year did not exceed the benefit threshold.

In each succeeding calendar year in which the reimbursement for Allowed Amounts does not exceed the benefit threshold, the Covered Person will be eligible for the carry over amount. The carry over amount can be accumulated from one to the next up to the maximum carry over amount unless:

a.) during any calendar year, Allowed Amounts are reimbursed in excess of the threshold. In this instance, there will be no additional carry over amount for the;

b.) during any calendar year, no claims for Allowed Amounts incurred during the preceding calendar year are submitted. In this instance, there will be no carry over amount for the

Eligibility for the carry over amount will be established or reestablished at the time for the first claim in a is received for Allowed Amounts incurred during the. In order to properly calculate the carry over amount, claims should be submitted timely.

You have the right to request review of prior carry over amount calculations. The request for review must be within 24 months from the date the carry over amount was established.

Maximum Plan Benefit

The Maximum Policy Benefit is $2,000 per Covered Person.

Maximum Plan Benefit applies to: ORTHODONTICS.

Section 1: Covered Dental Care Services

When Are Benefits Available for Covered Dental Care Services?

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

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

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

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

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

One example is:

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

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

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

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

Please note that in listing services or examples, when the Plan says "this includes," it is not the Plan's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Plan will state specifically that the list "is limited to."

Classes of Dental Benefits

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

Class I - Dental Benefits

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

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

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

Class II - Dental Benefits

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

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

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

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

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

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

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

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

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

Class III - Dental Benefits

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

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

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

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

Class IV - Dental Benefits

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

Virtual Visits

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

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

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

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

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

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

Prenatal Dental Care

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

Credit for Prior Coverage

If you are an Eligible Person that becomes covered under this Plan 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 plan's Deductible in order to receive credit under this Plan's applicable Deductible(s). You will also need to submit evidence of the total benefits paid under your prior plan in order to have the amount applied to this Plan's applicable Maximum(s).

Pre-Treatment Estimate

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

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

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

The pre-treatment estimate is valid for 90 calendar days from the date we provide it to the Dental Provider. If you will not receive the services within the 90 calendar days, you or the Dental Provider must request another pre-treatment estimate from the Claims Administrator.

Section 2: Exclusions and Limitations

The Plan Does Not Pay Benefits for Exclusions

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

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

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

Where Are Benefit Limitations Shown?

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

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

Exclusions

Except as may be specifically provided in the Schedule of Covered Dental Care Services or through an SMM or Amendment to the Plan, the following are not Covered Dental Care Services:

1. Dental Care Services that are not Necessary.
2. Hospitalization or other facility charges.
3. 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.
4. Any Dental Procedure not directly associated with dental disease.
5. Any Dental Procedure not performed in a dental setting.
6. Procedures that are considered to be Experimental, Investigational or Unproven. Any treatment, device or pharmacological regimen that is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be an Experimental, Investigational or Unproven Service.
7. Placement of dental implants, implant-supported crowns, abutments, and prostheses.
8. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
9. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to you by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. 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.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is due to patient non-compliance, the patient is liable for the cost of replacement.
13. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice, or the notice period as required by the Dental Provider in question.
14. Expenses for Dental Procedures begun prior to you becoming enrolled under the Plan.
15. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
16. 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.
17. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
18. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
19. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
20. Services rendered by a provider with the same legal residence as you or who is a member of your family, including but not limited to: spouse, brother, sister, parent or child.
21. Dental Care Services otherwise covered under the Plan, but rendered after the date individual Coverage under the Plan terminates, including Dental Care Services for dental conditions arising prior to the date individual Coverage under the Plan terminates.
22. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
23. Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, surgical procedure to correct a malocclusion, replacement of lost or broken retainers, and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan within 120 months of initial or supplemental placement.
24. In the event that an out-of-Network Dental Provider waives, does not pursue, or fails to collect, Copayments, Coinsurance and/or any deductible or other amount owed for a particular dental care service, no Benefits are provided for the dental care service when the Copayments, Coinsurance and/or deductible are waived.
25. Foreign Services are not covered unless required as an Emergency.
26. Dental Care Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
27. Any Dental Care Services or Procedures not listed in the Schedule of Covered Dental Care Services.

28. Services rendered while covered under this Plan which were also covered by a prior carrier will be reviewed based on current Plan Coverage. Any Plan Exclusions and/or limitations will apply based on when the Covered Dental Care Service was originally rendered, even when rendered while covered under a prior carrier.
29. Any Dental Care Service Covered under an essential health benefit plan is not covered under this Policy except for Orthodontic Dental Care Services.
30. Major restorative services relating to teeth that are not periodontally sound or that have a questionable prognosis of less than five years.
31. Surgical extractions of wisdom teeth.

Section 3: When Coverage Begins

How Do You Enroll?

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

To enroll, call the Plan Sponsor within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. If you wish to change your benefit elections due to your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the Plan Sponsor within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

Cost of Coverage

You and the Plan Sponsor share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld. In most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners eligible Dependents. Therefore, the value of the Plan Sponsor’s cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner may be paid using after-tax payroll deductions..

Your contributions are subject to review and the Plan Sponsor reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Plan Sponsor.

Who Is Eligible for Coverage?

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

Eligible Person

Eligible Person usually refers to an employee of the Plan Sponsor who (or other person whose connection with the Plan Sponsor) meets the eligibility rules. When an Eligible Person enrolls, the Claims Administrator refers to that person as a Participant. For a complete definition of Eligible Person, the Plan Sponsor and Participant, see *Section 9: Defined Terms*.

You are eligible to enroll in the Plan if you are a regular full-time employee who is scheduled to work at least 30 hours per week.

Eligible Persons must live within the United States.

If both spouses are Eligible Persons under the Plan Sponsor’s Plan, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both.

Dependent

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

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

If both parents of a Dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your Spouse.
- Your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- A child age 26 or over who is or becomes disabled and dependent upon you.
    - A Full-time Student.
    - Not regularly employed on a full-time basis.
    - Primarily dependent on you for support and maintenance.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A 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.

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

Coverage begins on the date shown in the Plan. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

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

Coverage begins on the date identified by the Plan Sponsor. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

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

Adding New Dependents

Participant's may enroll Dependents who join their family because of any of the following events:

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

Coverage for the Dependent begins on the date of the event. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the event.

Special Enrollment Period

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

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

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

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

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

- The Eligible Person previously declined coverage under the Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing dental coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including legal separation, divorce or death).
    - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
    - In the case of COBRA continuation coverage, the coverage ended.

- The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
- The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date coverage ended.

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

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

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

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

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Plan Ends**

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

- **You Are No Longer Eligible**

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

- **The Claims Administrator Receives Notice to End Coverage**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends on the last day of the calendar month in which the Claims Administrator receives the required notice from the Plan Sponsor to end your coverage, or on the date requested in the notice, if later.

- Participant **Receives Retires or Is Pensioned**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends on the last day of the calendar month in which Participant is retired or receiving benefits under the Plan Sponsor's pension or retirement plan.

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

Fraud or Intentional Misrepresentation of a Material Fact

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

If the Claims Administrator and the Plan Sponsor find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact the Plan

Sponsor has the right to demand that you pay back all Benefits the Plan paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Dependent Child

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

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

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

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

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

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

Extended Coverage for Total Disability

The Plan only pays Benefits for Covered Dental Care Services incurred by a Covered Person while you are covered by this plan for the following:

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

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

Continuation of Coverage

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

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

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

The Claims Administrator is not the Plan Sponsor's designated "plan administrator" as that term is used in federal law, and the Claims Administrator is does not assume any responsibilities of a "plan administrator" according to federal law.

The Claims Administrator is not obligated to provide continuation coverage to you if the Plan Sponsor or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Plan Sponsor or its plan administrator are:

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

Section 5: How to File a Claim

Claims Procedures

You can obtain a claim form by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. If you do not have a claim form, attach the bill from your provider to a brief letter of explanation. Verify that your provider's bill contains the Required Information listed below. If any Required Information is missing from the bill, you can include it in your letter.

How Are Covered Health Care Services from Network Providers Paid?

The Claims Administrator processes plan payments to Network Dental Providers directly for your Covered Dental Care Services. If a Network Dental Provider bills you for any Covered Dental Care Service, contact the Claims Administrator. However, you are required to meet any applicable deductible and to pay any required Copayments and Coinsurance to a Network Dental Provider. You will also be responsible for any charges that are not covered by the Plan to your Dental Provider.

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

When you receive Covered Dental Care Services from an out-of-Network Dental Provider, you will be required to pay all billed charges to your Dental Provider. You are also responsible for requesting payment from the Claims Administrator. You must file the claim in a format that contains all of the information the Claims Administrator requires, as described below.

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

Required Information

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

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

The above information should be filed with the Claims Administrator at Claims Department, P.O. Box 30567, Salt Lake City, UT 84130-0567 or by fax to 248-733-6060. If you would like to use a claim form, you may access a form on the Internet at www.myuhc.com or call the Claims Administrator at the telephone number on your ID card and a claim form will be provided to you.

Payment of Benefits

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to an out-of-Network Dental Provider without the Claims Administrator's consent. When an assignment is not obtained, the Claims Administrator will send the reimbursement directly to the Participant for reimbursement to an out-of-Network Dental Provider. The Claims Administrator reserves the right, in its discretion, to process Plan payment to an out-of-Network Dental Provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network Dental Provider, the Plan has the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan.

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

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

When the Claims Administrator has not consented to an assignment, the Claims Administrator will send the reimbursement directly to you (the Participant) for you to reimburse the provider upon receipt of their bill. However, the Claims Administrator reserves the right, in its discretion, to pay the provider directly for services rendered to you. When exercising its discretion with respect to payment, the Claims Administrator may consider whether you have requested that payment of your Benefits be made directly to the provider. Under no circumstances will the Claims Administrator pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a provider shall not be deemed to constitute consent by the Claims Administrator to an assignment or to waive the consent requirement. When the Claims Administrator in its discretion directs payment to a provider, you remain the sole beneficiary of the payment, and the provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, the Claims Administrator may in its discretion send information concerning the Benefits to the provider as well. If payment to a provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to Refund of Overpayments in Section 8: General Legal Provisions.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in a form of other consideration that the Claims Administrator in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes us, or to other plans for which the Claims Administrator processes payments where we the Plan has taken an assignment of the other plans' recovery rights for value,

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to an out-of-Network Dental Provider without the Claims Administrator's consent. When an assignment is not obtained, the Claims Administrator will send the reimbursement directly to the Participant for reimbursement to an out-of- Network Dental Provider. The Claims Administrator may, as we determine, pay an out-of-Network Dental Provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network Dental Provider, the Plan has the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan.

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

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

When the Claims Administrator has not consented to an assignment, the Claims Administrator will send the reimbursement directly to you (the Participant) for you to reimburse the provider upon receipt of their bill. However, the Claims Administrator reserves the right, in its discretion, to pay the provider directly for services rendered to you. When exercising its discretion with respect to payment, the Claims Administrator may consider whether you have requested that payment of your Benefits be made directly to the provider. Under no circumstances will the Claims Administrator pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a provider shall not be deemed to constitute consent by the Claims Administrator to an assignment or to waive the consent requirement. When the Claims Administrator in its discretion directs payment to a provider, you remain the sole beneficiary of the payment, and the provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, the Claims Administrator may in its discretion send information concerning the Benefits to the provider as well. If payment to a provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to Refund of Overpayments in Section 8: General Legal Provisions.

Section 6: Questions, Complaints and Appeals

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

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

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

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

How Do You Appeal a Claim Decision?

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

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

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

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare Dental Attention: Appeals

P.O. Box 30569

Salt Lake City, Utah 84130-0569

Appeal Process

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

Appeals Determinations

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

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

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

- For appeals of pre-service requests for Benefits as defined above, the first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

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

Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. The Claims Administrator will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Urgent Appeals that Require Immediate Action

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

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

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

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits to the Claims Administrator within:	48 hours after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	72 hours
If the Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an urgent care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	15 days
You must then provide completed request for Benefits information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial request for Benefits is complete, within:	15 days

Pre-Service Request for Benefits*

Type of Request for Benefits or Appeal	Timing
• after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*The Claims Administrator may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims

Type of Claim or Appeal	Timing
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial claim is complete, within:	30 days
• after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan Sponsor's Self-Funded group medical benefit plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

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

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

- **Primary Plan**. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan**. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 0% of the total Allowable Expense. Allowable Expense is defined below.

Definitions

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

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

1. Plan includes: group and non-group Plans and insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

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

secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 0% of the total Allowable Expense.

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

When the provider is a Network Dental Provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a out-of-Network Dental Provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a Out-of-Network Dental Provider for the primary plan and a Network Dental Provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a out-of-Network Dental Provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When this Plan is Secondary to Medicare". The following are examples of expenses or services that are not Allowable Expenses:

3. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

4. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

5. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

6. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

7. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

benefits are paid or provided before the entity has actual knowledge of the court decree provision.

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

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

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

(a) The Plan covering the Custodial Parent.

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

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

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

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

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

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

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

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

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

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

Effect on the Benefits of This Plan

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

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

Right to Receive and Release Needed Information

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

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

Payments Made

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

Does This Plan Have the Right of Recovery?

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

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future allowable expenses.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to Refund of Overpayments, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of you, you, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

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

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

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 0% of the allowable expense.

If this Plan is secondary to Medicare, it determines the amount it will pay for a Covered Health Care Services by following the steps below.

- The Plan determines the amount it would have paid had it been the only plan involved.
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.
- If the Plan would have paid more if it were the only plan involved, the difference between the amount it would have paid and the amount it actually paid is recorded as a benefit reserve for the Covered Person. This reserve can be used to pay any future allowable expenses not otherwise paid by the Plan during the.
- At the end of the calendar year, the benefit reserve returns to zero. A new benefit reserve is created for each.

The maximum combined payment you can receive from all plans may be less than 0% of the allowable expense.

Section 8: General Legal Provisions

What Is Your Relationship with the Claims Administrator?

It is important for you to understand the Claims Administrator's role with respect to the Group's Policy and how it may affect you. The Claims Administrator helps administer the claims payment for Plan Sponsor's Plan in which you are enrolled. The claims Administrator and the Plan do not provide dental care services or make treatment decisions. This means:

- The Claims Administrator communicates to you decisions about whether the Plan will cover or pay for the dental care that you may receive. The Plan pays for Covered Dental Care Services, which are more fully described in this *SPD*.
- The Plan may not pay for all dental care services or materials you or your Dental Provider may believe are needed. If the Plan does not pay, you will be responsible for the cost.

The Plan Sponsor and the Claims Administrator may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Plan Sponsor and the Claims Administrator will use individually identifiable information about you as permitted or required by law, including in the Claims Administrator's operations and in the Claims Administrator's research. The Plan Sponsor and the Claims Administrator will use de-identified data for commercial purposes including research.

Please refer to the Claims Administrator's *Notice of Privacy Practices* for details.

What Is the Claims Administrator's Relationship with Providers and Plan Sponsors

The Claims Administrator has agreements in place that govern the relationships between it and Plan Sponsors and Network Dental Providers, some of which are affiliated providers. Network Dental Providers enter into agreements with the Claims Administrator to provide Covered Health Dental Services to Covered Persons.

Plan Sponsors and the Claims Administrator do not provide dental care services or supplies, or practice medicine. Plan Sponsors and the Claims Administrator arrange for dental providers to participate in a Network and the Claims Administrator processes the Plan's payment of Benefits. Network Dental Providers are independent practitioners who run their own offices and facilities. The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. Network Dental Providers are not the Plan Sponsor's employees. Network Dental Providers are not the Claims Administrator's employees. The Plan Sponsor and the Claims Administrator The Plan Sponsor and the Claims Administrator are not responsible for any act or omission of any dental provider.

The Claims Administrator is not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator is not responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Policy.

The Plan Sponsor is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Plan's Service Fee to the Claims Administrator.
- The funding of Benefits on a timely basis.
- Notifying you of when the Plan ends.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §01 et seq., the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Plan Sponsors?

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

You are responsible for all of the following:

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

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

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

Notice

When the Claims Administrator provides provide written notice regarding administration of the Plan to an authorized representative of the Plan Sponsor, that notice is deemed notice to all affected Participant's and their Enrolled Dependents. The Plan is responsible for giving notice to you.

Statements by Plan Sponsor or Participant

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

Does the Claims Administrator Pay Incentives to Providers

The Claims Administrator pays Network Dental Providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network Dental Providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network Dental Providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network Dental Provider within the group to perform or coordinate certain health care services. The Network Dental Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

- Bundled payments - certain Network Dental Providers receive a bundled payment for a group of Covered Dental Care Services for a particular procedure or medical condition. Your Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network Dental Providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's dental care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Dental Care Services that are not considered part of the inclusive bundled payment and those Covered Dental Care Services would be subject to the applicable Copayment and/or Coinsurance as described in your Schedule of Covered Dental Care Services.

The Claims Administrator uses various payment methods to pay specific Network Dental Providers. From time to time, the payment method may change. If you have questions about whether your Network Dental Provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network Dental Provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Are Incentives Available to You?

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

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

Who Interprets Benefits and Other Provisions under the Plan?

The Plan Sponsor and the Claims Administrator have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *SPD*, the *Schedule of Covered Dental Care Services* and any Addendums, SMMs and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

The Plan Sponsor and the Claims Administrator may assign this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

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

Who Provides Administrative Services?

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

What is the Future of the Plan?

Although Plan Sponsor expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Plan Sponsor's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Plan Sponsor does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Plan Sponsor decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Plan Sponsor and others as may be required by any applicable law.

Amendments to the Plan

To the extent permitted by law, the Plan Sponsor has the right, as it determines and without your approval, to change, interpret, withdraw or add Benefits or end the Plan.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of applicable state law provisions not otherwise preempted by ERISA or federal statutes or regulations (of the jurisdiction in which the Plan is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

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

- Amendments, Addendums or SMMs to the Plan are effective upon the Plan Sponsor's next anniversary date, except as otherwise permitted by law.
- SMMs to the Plan are effective on the date the Plan Sponsor specifies.
- No agent has the authority to change the Plan or to waive any of its provisions.

- No one has authority to make any oral changes or amendments to the Plan.

How Does the Claims Administrator Use Information and Records?

The Claims Administrator may use your individually identifiable health information as follows:

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

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

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

The Claims Administrator has the right to release records concerning dental care services when any of the following apply:

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

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

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

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

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

Is Workers' Compensation Affected?

How Are Benefits Paid When You Are Medicare Eligible?

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

Subrogation and Reimbursement

The Plan has the right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

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

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 0% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

The following persons and entities are considered third parties:

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

You agree as follows:

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

    Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the

right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan has first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan has subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine" claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Claims Administrator, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit

stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without our written approval.
- The Plan has the final authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 0% of our interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian brings a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the Participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Policy. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of the Plan's final discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

When Does the Plan Receive Refunds of Overpayments?

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

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

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

If the refund is due from you and you do not promptly refund the full amount, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

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

Is There a Limitation of Action?

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

What Is the Entire Plan?

The *SPD*, the *Schedule of Covered Dental Care Services*, and any Addendums, SMMs and/or Amendments, make up the entire Plan.

Section 9: Defined Terms

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

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

For out-of-Network Benefits, when Covered Dental Care Services are received from out-of-Network Dental Providers, Allowed Amounts are Usual and Customary fees as defined below.

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

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

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

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

Claims Administrator - the organization that provides certain claim administration and other services for the Plan.

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

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

Consumer Max Multiplier - a provision that allows the unused portion of a Maximum Benefit to be carried over to the next if specified requirements are met.

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

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

- The Copayment.
- The Allowed Amount.

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

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

- Necessary.
- Treatment is recognized by the Claims Administrator as a generally accepted form of care or treatment according to prevailing standards of dental practice.

- Described as a Covered Dental Care Service in this *SPD* under *Section 1: Covered Dental Care Services* and in the *Schedule of Covered Dental Care Services*.
- Not excluded in this *SPD* under *Section 2: Exclusions and Limitations*.

Covered Person - the Participant or a Dependent, but this term applies only while the person is enrolled under the Plan. The Plan Sponsor "you" and "your" in this *SPF=D* to refer to a Covered Person.

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

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

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

The following conditions apply:

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

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

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

A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant

Domestic Partner - a person of the same or opposite sex with whom the Participant has a Domestic Partnership.

Domestic Partnership - a relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons. They must:

- Not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Share the same permanent residence and the common necessities of life.
- Be at least 18 years of age.
- Be mentally able to consent to contract.

- They must be financially interdependent.

The Participant and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

Eligible Person - an employee of the Plan Sponsor or other person connected to the Plan Sponsor who meets the eligibility requirements shown in both the Plan Sponsor's Plan and any supporting documents An Eligible Person must live within the United States.

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

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

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

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

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

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

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

Maximum Benefit - the maximum amount paid for Covered Dental Care Services during a year for you under the Plan or any Plan, issued by the Plan Sponsor, that replaces the Plan. The Maximum Benefit is stated in The Schedule of Covered Dental Care Services.

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

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

Necessary - dental care services and supplies which are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion:

- Through case-by-case assessments of care based on accepted dental practices to be appropriate.
- Needed to meet your basic dental needs.

- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Care Service.
- 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 Claims Administrator
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of you or your Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; or
    - Safe with promising efficacy:
        - for treating a life threatening dental disease or condition; and
        - in a clinically controlled research setting; and
        - using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

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

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

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

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

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

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

Participant - an Eligible Person who is properly enrolled under the Plan. The Participant is the person (who is not a Dependent) on whose behalf the Plan is issued to the Plan Sponsor and who meets the eligibility requirements specified in the Plan. A Participant must live and/or work in the United States.

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

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

Plan - the Plan Sponsor's Self-Funded group dental benefit plan.

The "What Is Summary Plan Description?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

Plan Sponsor - the employer, or other defined or otherwise legally established group, to whom the Plan is issued. The "What Is the Summary Plan Description?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

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

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

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

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

Spouse - an individual to whom you are legally married or a Domestic Partner as defined in this section.

Summary Material Modification (SMM) - any attached written description of additional Covered Health Care Services not described in this SPD. Covered Health Care Services provided by a SMM may be subject to payment of additional Service Fees. SMMs are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the SMM.

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

Usual and Customary fees must not exceed the fees that the Dental Provider would charge any similarly situated payor for the same services. In the event that a Dental Provider routinely waives Copayments and/or the applicable deductible for benefits, Dental Care Services for which the Copayments and/or the applicable deductible are waived are not considered to be Usual and Customary.

Usual and Customary fees are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator's reimbursement policy guidelines are developed by the Claims Administrator, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Dental Terminology*, a publication of the *American Dental Association*.
- As reported by generally recognized professionals or publications.

- As used for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination accepted by the Claims Administrator.