PO Box 30779

Salt Lake City, UT 84130-0779

800-955-4137

Solstice Certificate of Coverage

Group Dental

Notice: Any insurance Benefits in this Certificate will apply to an Employee only if: (a) he/she has elected that Benefit; or (b) he/she has a confirmation letter and/or a Solstice Identification Card, which shows his/her election of that Benefit.

Solstice Healthplans, Inc. ("Solstice") certifies that under the terms and conditions of the Policy issued to the Policyholder, the Policyholder became covered as of the Policy Effective Date indicated on the Group Contract and Solstice Identification Card received.

This Certificate of Coverage along with the Group Contract and Schedule of Benefits summarizes the provisions, limitations, and exclusions of the Policy issued to the Policyholder, and are subject to the terms of the Contract.

All periods of time under this Policy will begin and end at 12:01 a.m. local time at the Policyholder's address.

This Dental Plan is underwritten and administered by Solstice Healthplans, Inc., a Prepaid Limited Health Services Organization under the Florida Insurance Code.

Leonard A. Weiss

President

Important Information About Your Dental Plan

When You elected Benefits for Yourself and Your Dependents, You elected the following Dental Plan provided by Solstice:

S700B-SHP

Details of the Benefits under each of the above Dental Plans are described in separate Schedules of Benefits which are made part of the Certificate of Coverage.

When electing a Dental Plan initially or when changing Dental Plans as described below, the following rules apply:

- You and Your Dependents may enroll for only one of the Dental Plans.
- Your Dependents will be insured only if You are insured and only for the same Dental Plans.
- You may elect to change Dental Plans for Yourself and Your Dependents during any open enrollment period.

Definitions

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - A decision by Solstice not to authorize payment for specialty referrals on the basis of necessity of appropriateness of care. To be considered clinically necessary, the Dental Service must be reasonable and appropriate and must meet the following requirements:

- It must be consistent with the symptoms, diagnosis or treatment of the condition present.
- It must conform to commonly accepted standards throughout the dental field.
- It must not be used primarily for the convenience of the Member or Dentist.
- It must not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Request for payment authorizations that are declined by Solstice based upon the above will be the responsibility of the Member at the Dentist's Usual and Customary Fees. A Dentist will make any such denial.

Amendment - means any description of additional or alternative provisions that is attached to the Policy. Amendments are subject to all other terms, conditions, limitations, and exclusions of the Policy.

Benefits - means Covered Services provided directly by or through a Participating Provider.

Co-payment - The amount You owe to a Participating Provider for any Dental Services rendered that are listed on Your Schedule of Benefits.

Covered Person - means the Subscriber or Dependent currently enrolled in a Dental Plan who also meets all eligibility requirements specified in the Policy while the Policy is in effect. References to You and Your Dependents throughout this Certificate of Coverage are references to a Covered Person.

Covered Services - Dental Services that are listed as services covered on Your Schedule of Benefits.

Dental Office - The dental office of Your selected Participating Provider(s).

Dental Plan - Managed care dental plan offered through the Group Contract between Solstice and Your Group.

Dental Service - means dental care or treatment recognized by Solstice as a generally accepted form of care or treatment according to prevailing standards of dental practice that is provided by a Dentist.

Dental Service Area - The geographical area designated by Solstice within which it shall provide Dental Services.

Dentist - means any dental practitioner who is duly licensed and qualified under the law of the jurisdiction in which Dental Services are rendered.

Dependent - Your lawful spouse or domestic partner or Your unmarried child (including newborns, adopted children, stepchildren, a child for whom You must provide dental coverage under a court order; or a Dependent child who resides in Your home as a result of court order or administrative placement) who is:

- Less than 26 years old.
- Any age if he or she is both:
  - Incapable of self-sustaining employment due to mental or physical disability.
  - Reliant upon You for maintenance and support.

For a child who falls into category (2) above, You will need to furnish Solstice with evidence of his or her reliance upon You, in the form requested, within 31 days after the Dependent reaches the age of 26 and once a year thereafter during his or her term of coverage.

Coverage for Dependents living outside of the Solstice Dental Service Area are subject to the availability of an approved network where the Dependent resides.

This definition of Dependent applies unless it is modified by Your Group Contract.

Employee - means a person whose connection with the Group meets the eligibility requirements specified in the Policy, as prescribed by the Group (specifically including any minimum number of hours worked during a week and Employee Waiting Period) and as set out in the Group's application.

Emergency Condition - means a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe that his or her condition requires immediate Dental Services necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection.

Emergency Services - means dental screening, examinations, and evaluations provided to determine if an Emergency Condition exists. If it does, the care, treatment, or surgery reasonably necessary to relieve or eliminate the Emergency Condition which is sought or received within twenty-four (24) hours. Typical routine Emergency Services may include emergency examination, x-rays, extraction, prescription, or other palliative care to relieve immediate pain, infection and bleeding.

Employee Waiting Period - The time period in which an Employee must wait before being eligible for Benefits.

Enrollment Date - means the first day you are eligible to receive Covered Services under the Policy or, if earlier, the first day of the Employee Waiting Period that must pass with respect to you before you are eligible to receive Covered Services.

Group - An employer, labor union or other organization that has entered into a Group Contract with Solstice for managed Dental Services on Your behalf.

Group Contract/Policy - The entire Group Contract/Policy consists of the following:

- Part A - Group Dental Insurance Contract.
- Part B - Certificate of Coverage.
- Part C - Schedule of Benefits.
- Part D - All applications including, but not limited to, the Policyholder's application.
- Part E - Any Endorsements, Amendments and/or Riders to any or all of the above.

Member - means the Subscriber or enrolled Dependent meeting all eligibility requirements specified in the Policy while the Policy is in effect. References to You and Your Dependents throughout this Certificate of Coverage are references to a Covered Person.

Network - means a group of Dentists who are subject to a participation agreement in effect with us, directly or through another entity, to provide Dental Services to you. The participation status of Dentists may change from time to time.

Network General Dentist - A Dentist who has signed an agreement with Solstice under which he or she agrees to provide general Dental Services to You.

Network Specialty Dentist - A Dentist who has signed an agreement with Solstice under which he or she agrees to provide specialized Dental Services upon payment authorization by Solstice.

Participating Provider - A Dentist who has signed an agreement with Solstice to provide Dental Services to you as part of Solstice's Network. The term includes both Network General Dentists and Network Specialty Dentists.

Policy - means the Group Contract, the Certificate of Coverage, the application of the Group, Schedule of Benefits, Riders and/or Amendments that constitute the agreement regarding Covered Services, exclusions and other terms and conditions between Solstice and the Group.

Policyholder - Your Group/employer that has elected to sponsor this Policy and administrate it.

Premium/Prepayment Fees - Fees that Your Group remits to Solstice, on Your behalf, during the term of the Group Contract.

Rider - means any attached description of Covered Services under the Policy. Covered Services provided by a Rider may be subject to payment of additional Premiums. Riders are subject to all other terms, conditions, limitations, and exclusions of the Policy.

Schedule of Benefits - List of Covered Services under Your Dental Plan and how much they cost You.

Solstice Healthplans - The Solstice Healthplans, Inc. organization that provides Benefits in Florida.

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

Usual and Customary Fee - The customary fee that an individual Dentist most frequently charges for a given dental service.

You or **Your** - References to You or Your throughout the Policy are references to a Covered Person, Member, or Subscriber.

Introduction To Your Solstice Dental Plan

Welcome to the Solstice Dental Plan. We encourage You to use Your Dental Plan. Please note that enrollment in the Dental Plan allows the release of patient records to Solstice or its designee for administrative purposes and is to be considered in full satisfaction of all Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements and pertinent Florida Statutes.

Eligibility - When Coverage Begins

To enroll in the Dental Plan, You and Your Dependents must submit a written application for the Dental Plan on an approved Solstice application form and be able to seek treatment for Covered Services within a Solstice Dental Service Area. Other eligibility requirements may be determined by Your Group as set forth in the Group Contract. There will be at least one open enrollment period of not less than 30 days every 18 months unless Solstice and Your Group mutually agree to a period of time shorter than 18 months.

You the Subscriber

If You enrolled in the Dental Plan before the Effective Date of the Group Contract, You will be covered on the first day the Group Contract is effective. If You enrolled in the Dental Plan after the Effective Date of the Group Contract, You will be covered on the first day of the month following processing of Your enrollment (unless effective dates other than the first day of the month are provided for in Your Group Contract). If You are subject to an Employee Waiting Period, then this must be completed prior to eligibility which would commence on the first of the month following such completion.

Your Dependents

Your Dependents may be enrolled in the Dental Plan at the time You enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. All enrollments must be done through approved Solstice forms. You may drop coverage for Your Dependents only during the open enrollment periods for Your Group, unless there is a change in status such as divorce.

New Born/Adopted Children Coverage

If You have family coverage, a newborn child and/or an adopted child is automatically covered during the first 31 days of life/placement in the home or date of entry of an order granting You custody. If You wish to continue coverage beyond the first 31 days, Your newborn child and/or an adopted child needs to be enrolled in the Dental Plan by submitting an approved application and You need to begin to pay Premiums/Prepayment Fees, if any additional are due, during that period.

Family and Medical Leave Act of 1993

Under the Family and Medical Leave Act of 1993 (FMLA), You may be eligible to continue coverage during certain leaves of absence from work. During such leaves, You will be responsible for payment to Your Group the portion of the Premium/Prepayment fees, if any, which You would have paid if You had not taken the leave. You may be entitled to FMLA leave for any of the following reasons:

- The birth of a child, and to care for such child.
- The placement of a child with You for adoption or foster care.
- To care for Your seriously ill spouse, child, or parent.
- A serious health condition which makes You unable to perform Your job functions.

The Policyholder shall be responsible for the determination of Your eligibility, rights, or length of leave period for FMLA.

Initial Term

The Group Contract shall be in effect commencing at 12:01 A.M. on the Effective Date set forth in the Group Contract and shall extend for a minimum of 12 months thereafter.

Renewal Term(s)

The Group Contract is renewable at the option of the Group and Solstice at the end of the initial term for an additional 12 months (renewal term) and each renewal term may be renewed at the Group's option for an additional 12 months, subject to Solstice's right to modify/change, or amend the coverage and/or the Premium rates applicable for the renewal term. Any such changes/Amendments shall be subject to the Group's acceptance and shall be made part of the Group Contract. Solstice will offer renewal terms a minimum of 45 days in advance of the Group's anniversary date for signature by an authorized officer of Solstice. The agreement shall be deemed accepted and approved without the Group's signature if the first Premium due for the new contract year is paid to Solstice on or before the first day of the month of the new contract year.

Member/Dependent Disenrollment from the Dental Plan - Termination of Benefits

Except as otherwise provided in the sections titled Extension of Benefits and Continuation of Benefits (COBRA), or in Your Group Contract, disenrollment from the Dental Plan/Termination of Benefits and coverage will be as follows:

Subscriber

- The day the Policy terminates;
- The day Your employment terminates;
- The last day of the grace period which was enacted due to lack of Premium paid in the month prior;
- The last day of the month in which eligibility requirements are no longer met;
- The day You are no longer actively at work due to a labor dispute, including but not limited to, any strike, work slowdown or lockout;
- The day the Insured enters the Armed Forces of any country or international authority on a full time basis;
- Upon 60 days' notice from Solstice due to permanent breakdown of the Participating Provider/Subscriber relationship as determined by Solstice after at least three opportunities to utilize Dental Offices have failed;
- Upon 60 days' notice by Solstice due to fraud or misuse of dental services and/or dental offices;
- Upon 60 days' notice by Solstice due to continued lack of a Dental Office in Your service area;
- The last day of the month after voluntary disenrollment; or

- Upon any condition cited in the Group Contract.

Dependent

- The day the Policy terminates;
- The date on which the Policy is changed to end Dependent insurance;
- The date on which a Dependent ceases to be a Dependent as defined in the Policy;
- The last day of a period for which the required Premium payment for the cost of the Dependent is remitted;
- The day You request that the insurance for the Dependent be terminated;
- The day the Dependent enters the Armed Forces of any country or international authority on a full time basis;
- Upon all notices available by Solstice to the Member as stated in the Member termination provisions above; or
- When one of Your Dependents is disenrolled, You and Your other Dependents may continue to be enrolled. When You are disenrolled, Your Dependents will be disenrolled as well.

Extension of Benefits

Coverage for a specific Dental Service (other than orthodontics) which was started before Your disenrollment or Your Group's termination from the Dental Plan will be extended for a maximum of 90 days from the disenrollment/termination date. Your Participating Provider, by contract, is obligated to complete any and all Dental Services begun during the Dental Plan coverage period at the original contracted fees. Should this treatment be considered complex dentistry (ex. full mouth rehabilitation involving 6 or more crowns to be fabricated at the same time, periodontal therapy, etc.) as determined by the Solstice dental director, a decision will be rendered as to the additional time period that the Participating Provider needs to complete the original dental treatment plan.

Coverage for orthodontic treatment which was started before Member disenrollment/Group termination will be extended to the end of the quarter or for 90 days after Member disenrollment or Group termination whichever is later, unless such action was prompted due to nonpayment of Premiums in which case coverage ceases immediately.

Subrogation

When Benefits have been paid under the Policy for any loss caused by a third party, Solstice has the right to be reimbursed from any recovery the Insured obtains as a result of the alleged negligence. Solstice is entitled to any recovery even if such recovery does not fully satisfy the judgment, settlement, or underlying claim for damages or fully compensate the Insured. If the Insured is not fully compensated, Solstice shall be reimbursed on a pro-rata basis.

Solstice may take whatever legal action it sees fit against a third party to recover the Benefits paid under the Policy. This will not affect the Insured's right to pursue other forms of recovery, unless the Insured or his/her legal representative consent otherwise.

The Insured shall advise Solstice of a claim or suit against a third party or insurance carrier within 60 days of the action. Solstice has the right to the Insured's full cooperation. All procedures and provisions relating

to the right of subrogation shall not be in conflict with any applicable Florida Statute or the decisions of courts of competent jurisdiction which eliminate or restrict such rights.

Continuation of Benefits (COBRA)

For Groups with 20 or more Employees, federal law requires the employer to offer continuation of Benefits coverage for a Subscriber or Dependent after termination of employment or reduction of work hours, for any reason other than gross misconduct. Such reasons (qualifying event) include the following:

- The Subscriber's death;
- Termination of the Subscriber's employment (except for gross misconduct) or a reduction of hours below the minimum for eligibility;
- The Subscriber's divorce or legal separation;
- The Subscriber becoming eligible for Benefits under Medicare; and
- A Dependent child ceasing to be eligible under the terms of the Policy.

The maximum period of continued coverage for the Subscriber and his/her Dependents as a result of termination and/or reduction of hours is eighteen (18) months from the date of such event. The maximum period of continued coverage as a result of any qualifying event other than termination/reduction is thirty-six (36) months from the date of the event.

It is the responsibility of the Subscriber/Dependent to notify the Policyholder of a qualifying event other than termination and/or reduction of hours within 60 days of such event and make known his/her right for extension of Benefits.

It is the responsibility of the Policyholder to provide continued coverage, however it is the responsibility of the Subscriber/Dependent to remit the Premium for such coverage within 45 days after such election. Subsequent payments must be made to the Policyholder within 10 days of the Group's Premium due date.

Termination of the extended coverage will end at the earliest of the following dates:

- The end of the maximum period of continued coverage set forth;
- The date on which the Policyholder ceases to provide any Dental Plan;
- If an Subscriber/Dependent fails to make a Premium payment when due, the last day of the period of coverage for which Premiums have been paid; and
- The date on which the Subscriber/Dependent becomes covered under any other group dental plan or becomes eligible for benefits under Medicare.

Coordination of Benefits

If You or Your Dependents have other coverage, indemnity or otherwise, through Your spouse's employer or other sources, applicable coordination of Benefits rules will determine which coverage is primary or secondary. In most cases:

- The Dental Plan covering You as a Subscriber is primary for You.
- A plan covering Your spouse as a subscriber is primary for him/her.

- Your children are covered as primary by the plan of the parent whose birthday occurs earlier in the year.
- Utilizing two Benefits cannot result in reimbursement for more than 100% of the charge of the Dental Service rendered.

Grace Period

A grace period of 31 days will be allowed for the payment of any Premium except the first Premium due to enact the Policy. The Policy stays in force during a grace period. Full payment must be received by the 31st day of such a grace period. The Policy terminates at the end of the grace period with no further coverage.

The information below outlines the utilization of Your coverage and will help You to better understand how to make the best use of Your Dental Plan. Your particular Schedule of Benefits are attached to Your Certificate of Coverage which outlines each specific Covered Service, applicable Co-payments to these Covered Services, exclusions and limitations. Please refer to this document each and every time that You use Your Dental Plan.

Member Services

If You have any questions or concerns about Your Dental Plan, our Member Services representatives are just a toll-free phone call away. They can give You information on dental offices in Your area; explain certain dental services and their applicable Co-payments, second opinion or consultation; act as Your liaison with Your Dental Office; or explain Your Benefits. To contact Member Services from any location, call 1-800-955-4137.

Premiums

Your Group remits a monthly fee to Solstice for Members participating in the Dental Plan. The amount and term of this fee is set forth in Your Group Contract. You may contact Your Benefits representative for information regarding any part of the fee to be withheld from Your salary to be paid by You to the Group or the amount that the Group is paying on Your behalf.

Other Charges - Patient Charges

Your Schedule of Benefits lists the Covered Services under Your Dental Plan. Some Dental Services are covered at no charge to You while others require a Co-payment that is Your responsibility to be paid at the time that the Dental Service is rendered. There are no deductibles and no annual dollar limits for services covered by Your Dental Plan. Your Participating Provider receives supplemental payments from Solstice towards some "no charge" services as well as some services requiring Co-payments.

Your Network General Dentist should tell You about patient charges for Covered Services, the amount You must pay for non-Covered Services and the Dental Office's payment policies. It is possible that the Dental Office may add late charges to overdue balances or charges for broken appointments.

Your Schedule of Benefits is subject to annual change in accordance with Your Group Contract. Solstice will provide written notice to Your Group of any change in patient charges at least forty-five (45) days prior to such change. You will be responsible for the patient charges listed on the Schedule of Benefits that is in effect on the date a Covered Service is started.

Choice of Participating Provider

You and Your Dependents can select a Dental Office once enrolled in the Dental Plan. The Benefits of the Dental Plan are available only at a Dental Office within the Dental Service Area, except in the case of an emergency or when Solstice authorizes a payment for specialty referrals. Should You wish to change Your Participating Provider or Your Participating Provider elects to terminate their contract with Solstice, You have several help options:

- Contact Member Services at 1-800-955-4137;
- Request and/or review our printed Participating Provider Directory; or
- Visit us at www.myuhc.com and utilize our Participating Provider search feature.

It is You and Your Dependents' responsibility to review the Participating Provider Directory to ascertain whether there are sufficient Participating Providers in Your Dental Service Area. Solstice will make every effort to establish and maintain an adequate choice of Participating Providers throughout the state, however Solstice claims no responsibility should Network representation be diminished or eliminated through attrition of Participating Providers from the Solstice Network. Should all Participating Providers in a given service area elect to terminate after having been active at the time of Your enrollment in the Dental Plan, Solstice may tell You if You may obtain Covered Services at a particular non-Participating Provider on a temporary/emergency basis. In this situation, Solstice may pay the non-Participating Provider the difference, if any, between his or her usual fee and the applicable patient charge.

You may receive a description of the process used to analyze the qualifications and credentials of Participating Providers upon request.

Emergency Dental Care

Please contact Your Network General Dentist if You have an Emergency Condition in Your Dental Service Area.

If You have an Emergency Condition while You are out of Your Dental Service Area, You may receive Emergency Services as defined above from any Dentist. Routine restorative procedures or definitive treatment (e.g. root canal) which might be the final therapy necessary to correct the clinical situation creating the patient symptoms are not considered Emergency Services. You should return to Your Network General Dentist for these Dental Services. For emergency care there will be up to $100.00 reimbursement towards the abatement of pain.

Emergency Care After Hours

There is a patient charge listed on Your Schedule of Benefits for the emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable patient charges.

Benefit Limitations, Exclusions and Exceptions

Limitations on Covered Services

Listed below are limitations on Covered Services in Your Dental Plan:

- Frequency/Age - The frequency of certain Covered Services, specifically preventive and diagnostic procedures such as cleanings, x-rays, are limited. Your Schedule of Benefits lists these limitations on frequency and age.

- Specialty Care - All Members of Dental Plans 500B-SHP, 800B-SHP, and 300B-SHP may seek treatment from a Network Specialty Dentist without a referral from Solstice and/or Your Network General Dentist (we encourage the involvement of Your Network General Dentist so that proper coordination of treatment be considered in Your dental therapy). The Solstice Network Specialty Dentist will provide a 25% reduction off of his/her Usual and Customary Fee.

    - Should Your Dental Plan be the 500B-SHP and the services of an Orthodontic specialist be necessary, You may receive this care in either of two ways: (1) You may go directly to a Network Specialty Dentist with no referral and receive a 25% reduction off the Participating Provider's Usual and Customary Fee; or (2) You may obtain prior written authorization from Solstice and receive specialty treatment by an approved participating Orthodontic specialist at the listed Co-payments.

    Should Your Dental Plan be the S100B-SHP, S200B-SHP, S500B-SHP, S700B-SHP, S800B-SHP You have one of two options:

    - You may seek treatment from a Network Specialty Dentist without a referral from Solstice and/or Your Network General Dentist. The Network Specialty Dentist will provide a 25% reduction off of his/her Usual and Customary Fee; or

    - You may elect to obtain prior written authorization from Solstice and receive specialty treatment by a Network Specialty Dentist at the listed Co-payments on Your Schedule of Benefits should they appear there.

    Though it is the intent to provide easy access for Solstice Members to its Network Specialty Dentists, Solstice is not obligated to provide the required dental specialist within a specific radius or geographic area. The following general limitations apply:

    - Pediatric Dentistry - Coverage for referral to a pediatric Dentist ends on Your child's 16th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care after Your child's 16th birthday.

    - Oral Surgery - Surgical removal of impacted tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the Participating Provider's Usual and Customary Fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the Participating Provider's Usual and Customary Fees.

    - There are certain procedure codes listed in Your Schedule of Benefits that are not eligible under S-Plan reimbursement. These services are noted by an "iron cross".

    Please refer to the section "Specialty Care Protocol" for a review of the authorization procedure.

Orthodontics

The following definitions apply:

- Orthodontic Treatment Plan and Records- The preparation of orthodontic records and a treatment plan by the orthodontist(models, x-rays, etc.).

- Interceptive/Transitional Orthodontic Treatment- Treatment prior to full eruption of the permanent teeth, frequently a first phase prior to comprehensive therapy.

- Comprehensive Orthodontic Treatment- Treatment after eruption of most permanent teeth(i.e. braces).

- Retention(Post Treatment Stabilization) - The period following comprehensive treatment where You may wear an appliance to maintain and stabilize the new position of the teeth.

The Solstice orthodontic Benefit allows for a total of 24 months of orthodontic treatment whether it be entirely "comprehensive" or 12 months of "Interceptive" and 12 months of Comprehensive, etc. The patient charge for Your entire orthodontic case, including retention, will be based upon the appropriate Schedule of Benefits in effect on the date of Your visit for a treatment plan and records. Factors that could alter the total charge might be the type of brackets utilized (ceramic, clear, lingual vs. metal), required surgery, appliances to guide minor tooth movement, harmful habit appliances, as well as the evaluation of the difficulty or case type of the orthodontic treatment and/or the degree to which the treatment plan deviates from a "typical" or normal case difficulty as discerned entirely by the Orthodontist. Solstice bears no liability towards treatment unable to be completed due to a terminated status or a treatment planned case, originally thought to be completed within 24 months, at the end of which, more therapy is evident to achieve a satisfactory result as discerned by the Orthodontist.

If You and/or Your Dependent is in the middle of orthodontia treatment of any type at the time of initial enrollment, You must contact Solstice to see if You are eligible for reimbursement under the orthodontia Benefit.

Exclusions of Your Dental Plan

Listed below are the services or expenses which are NOT covered under Your Dental Plan and which are Your responsibility.

- Services not listed on the Schedule of Benefits are charged to You, the Subscriber/Dependent, at a 25% discount of the Participating Provider's Usual and Customary Fee.
- Services provided by a non-Network General Dentist or non-Network Specialty Dentist without Solstice's prior approval, except emergencies.
- Services related to an injury or illness paid under worker's compensation, occupational disease or similar laws.
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- Services related to injuries which are intentionally self-inflicted.
- Services required while serving in the Armed Forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- General anesthesia or IV sedation is available when listed on the Schedule of Benefits, medically necessary, and previously approved by Solstice.
- Prescription drugs.
- Procedures, appliances or restorations if the main purpose is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact) or (2) diagnose or treat abnormal conditions of the temporomandibular joint ("TMJ") unless TMJ therapy is specifically listed on Your Schedule of Benefits or specified as an orthodontic Benefit.
- Dental Services initiated prior to the Member's eligibility under this Dental Plan or initiated after the Member's termination from the Dental Plan.

- Replacement of fixed and/or removable prosthodontic or orthodontic appliances that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- Services associated with the placement or prosthodontic restoration of a dental implant.
- Services considered to be unnecessary or experimental in nature.
- Any inpatient/outpatient hospitalization, including any associated incremental charges for dental services/medical services performed in a hospital.
- Treatment of malignancies, cysts or neoplasms.
- Services to the extent You or Your enrolled Dependent is compensated under any group medical plan, no-fault auto insurance policy, or an insured motorist policy.
- Any Dental Service unable to be performed in the Dental Office due to the general health or physical limitations of the Member including, but not limited to physical or emotional resistance, inability to visit the Dental Office, or allergy to commonly utilized local and or general anesthetics.
- Surgical removal of impacted tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the Participating Provider's Usual and Customary Fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the Participating Provider's Usual and Customary Fees.

Pre-existing Conditions

There are no pre-existing conditions. Should any be added as an addendum to the Contract upon renewal, pre-existing conditions will not be excluded, for a condition which occurs 3 months prior to the effective date, for more than two years.

Exceptions

Within each particular Schedule of Benefits, there may be additional Co-payments, fees, surcharges that apply to services that present with a Co-payment (e.g. precious metal Co-payment when undergoing crown restoration therapy, complex rehabilitation/multiple crowns of 6 or more requiring a $30.00 surcharge). Please review Your entire Schedule of Benefits to determine whether such additional charges apply.

Genetic, Handicapped and Communicable Disease Conditions

Solstice, in compliance with Florida Statutes and Florida Administrative Code, does not consider Members with the following conditions subject to limited, altered, or denied coverage, by virtue of these specific conditions alone:

- HIV.
- Handicapped children.
- Genetic information absent of a condition requiring diagnosis.

Solstice, in the course of its business, complies with the following Florida Statues/Administrative Codes:

- Section 636.016, Florida Statutes
- Rule 69O-203.025, Florida Administrative Code

- Section 636.0201, Florida Statutes
- Section 636.022, Florida Statutes
- Section 627.4301, Florida Statutes

Grievance Procedures - What To Do If There Is A Problem

Most problems can be resolved between You and Your Participating Provider. We suggest that You discuss Your questions and/or concerns with Your Participating Provider first in the hopes of continuing to maintain an easy working relationship. However, we want You to be completely satisfied with the Dental Plan. That's why we've established a process for addressing Your concerns and complaints. The complaint procedure is voluntary and will be used only upon Your request.

Informal Grievance Procedure

Begin with the Member Services Department which can be reached at 1-800-955-4137. We are here to listen and to help. If You have a concern about Your Dental Office or the Dental Plan, You may call the toll-free number and explain Your concern to one of the Member Services representatives. Many questions/concerns are able to be addressed at the time of Your first phone call by reviewing Your Dental Plan, normal Solstice procedures as described in this Certificate of Coverage, and interpreting what might appear to be complicated typical Dental Office procedure. If necessary, and only under Your direction, we will contact Your Participating Provider for You to gain necessary treatment information. We will evaluate such information as it pertains to Your concern and get back to You as soon as possible, usually by the end of the next business day. Should You consider this informal grievance procedure unsatisfactory, Solstice employs a two level "Appeals" process for any disputes and/or concerns.

Level One Complaint-Appeal

Even though it is not necessary, it is always assumed that You have attempted to have Your concern(s) addressed through our informal process prior to utilizing the "Level One" formal process. To initiate a "Level One" complaint or appeal towards the findings of an informal query, You must submit a request for review of such a complaint/appeal within one (1) year of the occurrence, to include the following information:

- The letter should be labeled as a "Level One" complaint/Appeal.
- Patient identifying information.
- Participating Provider identifying information.
- The date(s) of the experience.
- Description of the intended dental service.
- The nature of the deviation.
- The patient financial obligation toward the Participating Provider, if any.
- The overall temperament/attitude of the Participating Provider and his/her auxiliaries.
- A review of Your attempt, if any, to clarify/correct the Participating Provider deviation.
- A review of the Participating Provider's attempt, if any, to clarify/correct the deviation.
- A review of the Informal grievance process by Yourself and Solstice if one had occurred.

The above letter should be addressed to:

Appeals Coordinator

PO Box 30569

Salt Lake City, UT 84130-0569

If You are unable or choose not to submit a written request, You may ask Member Services/Appeals Coordinator to register Your request by calling the toll-free number 1-800-955-4137 at which time the Member Services representative will fill out a formal grievance form. Once completed, this formal grievance form will be mailed to You for Your signature to be returned to Solstice for action.

Your "Level One" request will be considered and the resolution made by someone not involved in the initial decision or occurrence. Issues involving dental necessity or clinical appropriateness will be considered by a dental professional.

We will respond with a decision within 15 calendar days after we receive Your request. If the review cannot be completed before 15 days, we will notify You on or before the 15th day of the reason for the delay. The review will be completed within 15 calendar days after that. If You are not satisfied with our decision, You may request a second level review.

Level Two Appeal

To initiate a level two appeal, You must submit Your request in writing to Solstice within 60 days after receipt of Solstice's level one decision.

Second level reviews will be conducted by Solstice's Appeals Committee, which consists of a minimum of 3 people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving dental necessity or clinical appropriateness, the Appeals Committee will include at least one Dentist. If specialty care is in dispute, the Appeals Committee will consult with a Dentist in the same or similar specialty as the care under consideration, as determined by Solstice.

Solstice will acknowledge Your appeal in writing within five (5) business days and schedule a committee review. The acknowledgement will include the name, address, and telephone number of the Appeals Coordinator. Additional information may be requested at that time. The review will be held within 30 calendar days. If the review cannot be completed within 30 calendar days, You will be notified in writing on or before the 15th calendar day, and the review will be completed no later than 45 days after the receipt of Your initial request.

You may present Your situation to the Appeals Committee in person or by conference call. Please advise Solstice five (5) days in advance if You or Your representative plans to be present. The location of the review will be at the Solstice home office address or at a location within Your service area that is mutually convenient. You will be notified in writing of the Appeals Committee decision within 5 business days after the Appeals Committee meeting. The resolution will include the specific contractual or clinical reasons for the resolution, as applicable.

Expedited Appeals

You may request that the complaint or appeal resolution be expedited if the timeframes under the above process would seriously jeopardize Your life or health or would jeopardize Your ability to regain the dental functionality that existed prior to the onset of Your current condition. A dental professional, in consultation with the treating Participating Provider, will decide if an expedited review is necessary. When a review is expedited, Solstice will respond orally with a decision within 72 hours, followed up in writing within two business days of the decision.

Appeals to the State

You have the right to contact Your state's Department of Insurance or Health for assistance at any time. Such contact can be made at the following address:

Department of Financial Services

200 East Gaines Street

Tallahassee, Florida 32399

1-800-342-2762

Arbitration

As a Solstice enrollee, You acknowledge that any/all grievances, upon Your request, may be placed in an arbitration process so that an agreeable resolution may be established. All arbitration processes will not preclude review pursuant to Rule 69O-191.078 of the Florida Administrative Code and shall be conducted pursuant to Chapter 682 of the Florida Statues.

Solstice will not cancel or refuse to renew coverage because You or Your Dependent has filed a complaint or appealed a decision made by Solstice. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a Dentist.

Solstice S700B-SHP/D1068

Members of the Solstice S700B-SHP Dental Plan are eligible to receive benefits immediately upon the effective date of coverage with:

- No Waiting Periods
- No Deductibles or Maximums
- No Claim Forms to Submit

The member co-payments listed are offered by a participating in-network general dentists. The member receives:

- Most diagnostic & preventive care at No Charge
- Cosmetic & orthodontia treatment covered

Members can locate a participating provider at
www.myuhc.com
Member Services Department: 800-955-4137

The member is ultimately responsible for verifications of the accuracy and appropriateness of all fees applicable to any dental benefit provided by a network provider. We urge all of our members to verify all fees for proposed treatment via the "Schedule of Benefits" and/or with our Member Services Department prior to treatment.

The following Member co-payments apply when a participating General Dentist performs services. An "*" denotes limitations on certain benefits (see "Exclusions/Limitations").

ADA	DESCRIPTION	MEMBER PAYS
DIAGNOSTIC SERVICES		
D0120*	PERIODIC ORAL EVALUATION EST PT	$0*
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	$0
D0145*	ORAL EVAL PT<3 AND COUNSEL	$0*
D0150*	COMP ORAL EVALUATION - NEW/EST PT	$0*
D0160*	DTL & EXT ORAL EVAL - PROBLEM FOCUS REPORT	$0*
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	$0
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE VISIT	$0
D0180*	COMP PERIODONTAL EVAL - NEW/EST PT	$0*
D0210*	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC IMAGES	$0*
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$4
D0230	INTRAORL PERIAPICAL EACH ADD RADIOGRAPHIC IMAGE	$2
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	$0
D0251*	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	$0*
D0270*	BITEWING - SINGLE RADIOGRAPHIC IMAGE	$0*
D0272*	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$0*
D0273*	BITEWINGS - THREE RADIOGRAPHIC IMAGES	$0*
D0274*	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$0*
D0277*	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$29*
D0310	RADIOGRAPHS -SIALOGRAPHY	$150
D0320	TMJ - INCLUDING INJECTION	$250
D0321	OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES	$150
D0322	TOMOGRAPHIC SURVEY	$150
D0330*	PANORAMIC RADIOGRAPHIC IMAGE	$50*
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	$125
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY	$20
D0364*	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$169*
D0365*	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$149*
D0366*	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$139*
D0367*	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS	$139*
D0368*	CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$184*
D0369*	MAXILLOFACIAL MRI CAPTURE AND INTERPRETATION	$139*
D0370*	MAXILLOFACIAL ULTRASOUND CAPTURE AND INTERPRETATION	$189*
D0371*	SIALOENDOSCOPY AND CAPTURE AND INTERPRETATION	$169*
D0380*	CONE BEAM CT IMAGE CAPTURE WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$169*
D0381*	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$149*
D0382*	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$139*
D0383*	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF BOTH JAWS	$139*
D0384*	CONE BEAM CT IMAGE CAPTURE FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$184*
D0385*	MAXILLOFACIAL MRI IMAGE CAPTURE	$139*

This plan is underwritten by Solstice, Inc. Administered by Dental Benefit Providers, Inc.

ADA	DESCRIPTION	MEMBER PAYS
DIAGNOSTIC SERVICES		
D0386*	MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE	$169*
D0393*	SIMULATION USING 3D IMAGES	$9*
D0394*	DIGITAL SUBTRACTION OF IMAGES	$9*
D0395*	FUSION OF TWO OR MORE 3D IMAGES	$9*
D0415	COLLECT MICROORGANISMS CULT & SENS	$0
D0425	CARIES SUSCEPTIBILITY TESTS	$0
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	$65
D0460	PULP VITALITY TESTS	$0
D0470	DIAGNOSTIC CASTS	$0
D0472	ACCESS TISSUE, GROSS EXAM - PREP & REPORT	$0
D0473	ACCESS TISSUE, GROSS & MICROSCOPIC - PREP/REPORT	$0
D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG MARG PREP/REPORT	$0
D0480	PROCESSING AND INTERP OF EXFOLIATIVE CYTOLOGICAL SMEARS, INCL PREP AND TRANS OF WRITTEN REPORT	$0
D0486	ACCESSION OF TRANSEPITHELIAL CYTOLOGIC SAMPLE, MICCROSCOPIS EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	$0
D0502	OTHER ORAL PATHOLOGY PROCEDURES	$0
D0600	NON-IONIZING DIAGNOSTIC PROCEDURE CAPABLE OF QUANTIFYING, MONITORING, AND RECORDING CHANGES IN STRUCTURE OF ENAMEL, DENTIN AND CEMENTUM	$0
D0601	CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	$0
D0602	CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	$0
D0603	CARIES RISK ASSESSMENT AND DOCUMENTATION, HIGH	$0
D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	$50
D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	$125
D0703	2-D ORAL/FACIAL PHOTOGRAPHIC IMAGE INTRA-ORALLY OR EXTRA-ORALLY–IMAGE CAPTURE ONLY	$20
D0705	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE–IMAGE CAPTURE ONLY	$0
D0706	INTRAORAL–OCCLUSAL RADIOGRAPHIC IMAGE–IMAGE CAPTURE ONLY	$0
D0707	INTRAORAL–PERIAPICAL RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	$2
D0708	INTRAORAL–BITEWING RADIOGRAPHIC IMAGE–IMAGE CAPTURE ONLY	$0
D0709	INTRAORAL–COMPLETE SERIES OF RADIOGRAPHIC IMAGES–IMAGE CAPTURE ONLY	$0
PREVENTIVE SERVICES		
D1110*	PROPHYLAXIS - ADULT	$0*
D1110*	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN 6 MONTHS	$20*
D1120*	PROPHYLAXIS - CHILD	$0*
D1120*	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6 MONTHS	$20*
D1206*	TOPICALFLUORIDE VARNISH	$15*
D1208*	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	$0*
D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	$0
D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	$0
D1330	ORAL HYGIENE INSTRUCTIONS	$0
D1351*	SEALANT - PER TOOTH	$0*
D1352*	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	$0*
D1353	SEALANT REPAIR – PER TOOTH	$0
D1354	APPLICATION OF CARIES ARRESTING MEDICAMENT–PER TOOTH	$20
D1355	CARIES PREVENTIVE MEDICAMENT APPLICATION – PER TOOTH	$20
D1510*	SPACE MAINTAINER - FIXED, UNILATERAL/QUAD	$0*
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	$0
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	$0
D1520*	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	$0*
D1526*	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	$0*
D1527*	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	$0*
D1551	RECEM/REBOND BILATERAL SPACE MAINTAINER – MAXIL	$15
D1552	RECEM/REBOND BILATERAL SPACE MAINTAINER – MANDIB	$15
D1553	RECEM/REBOND UNILATERAL SPACE MAINTAINER/QUAD	$15
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER/QUAD	$15
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	$15
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIB	$15
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED, UNILATERAL/QUAD	$0
RESTORATIVE SERVICES		
D2140	AMALGAM - ONE SURFACE PRIMARY/PERMANENT	$0
D2150	AMALGAM - TWO SURFACES PRIMARY/PERMANENT	$0
D2160	AMALGAM - 3 SURFACES PRIMARY/PERMAMENT	$0
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	$0
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	$30
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	$37
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	$50
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	$80
D2390	RESIN COMPOSITE CROWN ANTERIOR	$115
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	$65
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	$75
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	$90
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	$115
D2410	GOLD FOIL - ONE SURFACE	$75
D2420	GOLD FOIL - TWO SURFACES	$95
D2430	GOLD FOIL - THREE SURFACES	$125

ADA	DESCRIPTION	MEMBER PAYS
RESTORATIVE SERVICES		
D2510	INLAY - METALLIC - ONE SURFACE	$225
D2520	INLAY - METALLIC - TWO SURFACES	$235
D2530	INLAY - METALLIC - 3/MORE SURFACES	$245
D2542	ONLAY - METALLIC - TWO SURFACES	$325
D2543	ONLAY - METALLIC THREE SURFACES	$340
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	$350
D2610*	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	$275*
D2620*	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	$300*
D2630*	INLAY - PORCELAIN/CERAMIC - 3/MORE SURFACES	$325*
D2642*	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	$360*
D2643*	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	$390*
D2644*	ONLAY - PORCELAIN/CERAMIC - 4/MORE SURFACES	$400*
D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	$200
D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	$220
D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	$260
D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	$240
D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	$260
D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	$283
D2710*	CROWN - RESIN - BASED COMPOSITE INDIRECT	$195*
D2712*	CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT	$195*
D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	$245*
D2721*	CROWN - RESIN W/PREDOM BASE METAL	$245*
D2722*	CROWN - RESIN WITH NOBLE METAL	$245*
D2740*	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$245*
D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	$245*
D2751*	CROWN - PORCELAIN FUSED PREDOM BASE METAL	$245*
D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	$245*
D2753	CROWN PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$245
D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	$245*
D2781*	CROWN - 3/4 CAST PREDOM BASE METAL	$245*
D2782*	CROWN - 3/4 CAST NOBLE METAL	$245*
D2783*	CROWN - 3/4 PORCELAIN/CERAMIC	$245*
D2790*	CROWN - FULL CAST HIGH NOBLE METAL	$245*
D2791*	CROWN - FULL CAST PREDOM BASE METAL	$245*
D2792*	CROWN - FULL CAST NOBLE METAL	$245*
D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	$245*
D2799*	INTERIM CROWN–FURTHER TRTMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	$125*
D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	$15
D2915	RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFABRICATED POST & CORE	$20
D2920	RECEMENT OR RE-BOND CROWN	$15
D2921	REATTACHMENT OF TOOTH FRAGMENT	$15
D2928	PREFABRICATED PORCELAIN/CERAMIC CROWN – PERMANENT TOOTH	$49
D2929*	PREFABRICATED PORCELAIN CROWN- PRIMARY	$49*
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY	$45
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT	$55
D2932	PREFABRICATED RESIN CROWN	$95
D2933	PREFABRICATED STAINLESS STEEL CROWN RESIN WINDOW	$145
D2940	SEDATIVE FILLING	$15
D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$15
D2949	RESTORATIVE FOUNDATION FOR AN INDIRECT RESTORATION	$20
D2950	CORE BUILDUP INCLUDING ANY PINS	$70
D2951	PIN RETENTION - PER TOOTH ADDITION REST	$15
D2952	POST & CORE ADD CROWN INDIRECT FAB	$88
D2953	EACH ADD INDIRECT FABRICATED POST SAME TOOTH	$95
D2954	PREFABRICATED POST & CORE ADDITION CROWN	$75
D2955	POST REMOVAL	$30
D2957	EACH ADD PREFABR POST - SAME TOOTH	$30
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	$200
D2961*	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	$255*
D2962*	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	$390*
D2971	ADDL PROC CUSTOMIZE CROWN TO FIT UNDER XST PART DENTURE	$45
D2975	COPING	$95
D2980	CROWN REPAIR	$95
D2981	INLAY REPAIR	$95
D2982	ONLAY REPAIR	$95
D2983	VENEER REPAIR	$95
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	$29
ENDODONTIC SERVICES		
D3110	PULP CAP - DIRECT	$25
D3120	PULP CAP - INDIRECT	$25
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL JUNC	$30
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT TEETH	$95
D3222	PARTIAL PULPOTOMY	$75
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	$50
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	$50
D3310	ANTERIOR	$110
D3320	BICUSPID	$195
D3330	MOLAR	$245
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	$85
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	$75
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	$125
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	$300
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	$350
D3348	RETX PREVIOUS RC THERAPY - MOLAR	$440
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	$90
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	$90
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	$90
D3410	APICOECTOMY SURG - ANT	$100

ADA	DESCRIPTION	MEMBER PAYS
ENDODONTIC SERVICES		
D3421	APICOECTOMY SURG-BICUSPID	$315
D3425	APICOECTOMY SURG - MOLAR	$340
D3426	APICOECTOMY SURGERY	$95
D3428	BONE GRAFT WITH PERIRADICULAR SURGERY PER TOOTH	$47
D3429	BONE GRAFT WITH PERIRADICULAR SURGERY EACH ADDITIONAL TOOTH	$42
D3430	RETROGRADE FILLING - PER ROOT	$75
D3431	BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION	$150
D3432	GUIDED TISSUE REGENERATION, RESORBABLE BARRIER, PER SITE	$150
D3450	ROOT AMPUTATION - PER ROOT	$110
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$545
D3470	INTENTIONAL REIMPLANTATION (INCLUDING NECESSARY SPLINTING)	$175
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	$100
D3472	SURGICAL REPAIR OF ROOT RESORPTION – PREMOLAR	$315
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR	$340
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR ROOT RESORPT-ANTERIOR	$100
D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR OF ROOT RESORPT–PREMOLAR	$100
D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR OF ROOT RESORPT–MOLAR	$100
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	$95
D3911	INTRAORIFICE BARRIER	$65
D3920	HEMISECTION NOT INCL RC THERAPY	$90
D3921	DECORONATION OR SUBMERGENCE OF AN ERUPTED TOOTH	$30
D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	$75
PERIODONTIC SERVICES		
D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	$175
D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD	$81
D4212	GINGIVECTOMY/GINGIVOPLASTY WITH REST PROC/TOOTH	$49
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$195
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$185
D4245	APICALLY POSITIONED FLAP	$150
D4249	CLIN CROWN LEN - HARD TISSUE	$230
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$375
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$325
D4263	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT	$450
D4264	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – EACH ADDITIONAL SITE IN QUADRANT	$325
D4265	BIOLOGIC MATERIALS TO AID SOFT AND OSSEOUS TISSUE REGEN, PER SITE	$82
D4266	GUIDED TISSUE REGENERATION - RESORBABLE BARRIER, PER SITE	$325
D4267	GUIDED TISSUE REGENERATION - NONRESORBABLE BARRIER, PER SITE (INCLUDES MEMBRANE REMOVAL)	$325
D4268	SURGICAL REVISION PROCEDURE, PER TOOTH	$0
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$250
D4273	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, 1ST TOOTH	$335
D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	$125
D4275	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, 1ST TOOTH	$502
D4276	COMBINED CONNECTIVE TISSUE AND PEDICLE GRAFT, PER TOOTH	$65
D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH	$215
D4278	FREE SOFT TISSUE GRAFT PROCEDURE - ADD TOOTH	$75
D4283	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURIGCAL SITES – EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	$299
D4285	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURIGCAL SITES – EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	$392
D4322	SPLINT–INTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	$115
D4323	SPLINT–EXTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	$105
D4341†*	PERIODONTAL SCAL & ROOT PLAN 4/>TEETH-QUAD	$50†*
D4342†*	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	$43†*
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	$50
D4355†*	FULL MOUTH DEBRID COMP ORAL EVAL & DX ON A SUBSEQUENT VISIT	$50†*
D4381†*	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$60†*
D4910*	PERIODONTAL MAINTENANCE	$50*
D4920	UNSCHEDULED DRESSING CHANGE	$25
D4921	GINGIVAL IRRIGATION PER QUADRANT	$15
D4999	UNSPECIFIED PERIODONTAL PROCEDURE, BY REPORT	$0
REMOVABLE PROSTHODONTIC SERVICES		
D5110*	COMPLETE DENTURE - MAXILLARY	$325*
D5120*	COMPLETE DENTURE - MANDIBULAR	$325*
D5130*	IMMEDIATE DENTURE - MAXILLARY	$350*
D5140*	IMMEDIATE DENTURE - MANDIBULAR	$350*

ADA	DESCRIPTION	MEMBER PAYS
REMOVABLE PROSTHODONTIC SERVICES		
D5211*	MAXILLARY PARTIAL DENTURE - RESIN BASE	$400*
D5212*	MANDIBULAR PARTIAL DENTURE - RESIN BASE	$400*
D5213*	MAX PART DENTUR-CAST METL W/RSN	$425*
D5214*	MAND PART DENTUR- CAST METL W/RSN	$425*
D5221*	IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$420*
D5222*	IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$420*
D5223*	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$445*
D5224*	IMMEDIATE MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$445*
D5225*	MAXILLARY PARTIAL DENTURE FLEX BASE	$425*
D5226*	MANDIBULAR PARTIAL DENTURE FLEX BASE	$425*
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE-FLEX BASE	$420
D5228	IMMEDIATE MANDIBULAR PARTIAL DENTURE-FLEX BASE	$420
D5282*	REMOVABLE UNILATERAL PARTIAL DENTURE - MAXILLARY	$245*
D5283*	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	$245*
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$15
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	$15
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$15
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$15
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	$35
D5512	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	$35
D5520*	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	$35*
D5621*	REPAIR CAST PARTIAL FRAMEWORK - MANDIBULAR	$35*
D5622*	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	$35*
D5630*	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	$35*
D5640*	REPLACE BROKEN TEETH - PER TOOTH	$35*
D5650*	ADD TOOTH EXISTING PARTIAL DENTURE	$35*
D5660*	ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	$35*
D5670*	REPLACE ALL TEETH & ACRYLC FRMEWRK MAXILLARY	$155*
D5671*	REPLACE ALL TEETH & ACRYLC FRMEWRK MANDIBULAR	$155*
D5710*	REBASE COMPLETE MAXILLARY DENTURE	$135*
D5711*	REBASE COMPLETE MANDIBULAR DENTURE	$135*
D5720*	REBASE MAXILLARY PARTIAL DENTURE	$155*
D5721*	REBASE MANDIBULAR PARTIAL DENTURE	$155*
D5725	REBASE HYBRID PROSTHESIS	$135
D5730*	RELINE CMPL MAXIL DENTURE (DIRECT)	$65*
D5731*	RELINE CMPL MAND DENTURE (DIRECT)	$65*
D5740*	RELINE MAXIL PART DENTURE (DIRECT)	$65*
D5741*	RELINE MAND PART DENTURE (DIRECT)	$65*
D5750*	RELINE CMPL MAXIL DENTURE (INDIRECT)	$85*
D5751*	RELINE CMPL MAND DENTURE (INDIRECT)	$85*
D5760*	RELINE MAXIL PART DENTURE (INDIRECT)	$85*
D5761*	RELINE MAND PART DENTURE (INDIRECT)	$85*
D5765	SOFT LINER FOR COMPLETE OR PART REMOVABLE DENTURE–INDIRECT	$20
D5810*	INTERIM COMPLETE DENTURE (MAXILLARY)	$250*
D5811*	INTERIM COMPLETE DENTURE (MANDIBULAR)	$250*
D5820*	INTERIM PARTIAL DENTURE MAXILLARY	$175*
D5821*	INTERIM PARTIAL DENTURE MANDIBULAR	$175*
D5850	TISSUE CONDITIONING MAXILLARY	$20
D5851	TISSUE CONDITIONING MANDIBULAR	$20
D5862	PRECISION ATTACHMENT, BY REPORT	$150
D5899	UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT	$0
IMPLANT SERVICES		
D6010*	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$1,010*
D6012*	SURGICAL PLACEMENT OF INTERIM IMPLANT BODY FOR TRANSITIONAL PROSTHESIS: ENDOSTEAL IMPLANT	$1,010*
D6056*	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	$440*
D6057*	CUSTOM FAB ABUTMENT - INCLUDES PLACEMENT	$550*
D6058*	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$750*
D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	$750*
D6060*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	$750*
D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	$750*
D6062*	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$750*
D6063*	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL)	$750*
D6064*	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	$750*
D6065*	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$750*
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$750*
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	$750*
D6068*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	$750*
D6069*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	$750*
D6070*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	$750*

ADA	DESCRIPTION	MEMBER PAYS
IMPLANT SERVICES		
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	$750*
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	$750*
D6073*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	$750*
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	$750*
D6075*	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$750*
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$750*
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS	$750*
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS	$180
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE	$50
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$750
D6083	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS	$750
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$750
D6085	INTERIM IMPLANT CROWN	$125
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE ALLOYS	$750
D6087	IMPLANT SUPPT CROWN-NOBLE ALLOYS	$750
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM ALLOYS	$750
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	$400
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	$45
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	$65
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	$750*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	$220
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	$500
D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$750
D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$750
D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	$750
D6100	SURGICAL REMOVAL OF IMPLANT BODY	$700
D6110*	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$1,255*
D6111*	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$1,255*
D6112*	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$995*
D6113*	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$995*
D6114*	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$3,855*
D6115*	IMPLANT /ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$3,855*
D6115*	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$3,855*
D6116*	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$2,255*
D6117*	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$2,255*
D6118	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	$1,804
D6119	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MAXILLARY	$1,804
D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$750
D6121	IMPLANT SUPPT RETAINER FOR METAL FPD-PREDOM. BASE ALLOYS	$750
D6122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	$750
D6123	IMPLANT SUPPT RETAINER FOR METAL FPD-TITANIUM/TITANIUM ALLOYS	$750
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	$235
D6198	REMOVE INTERIM IMPLANT COMPONENT	$700
FIXED PROSTHODONTIC SERVICES		
D6205*	PONTIC- INDIRECT RESIN BASED COMPOSITE	$750*
D6210*	PONTIC - CAST HIGH NOBLE METAL	$245*
D6211*	PONTIC - CAST PREDOM BASE METAL	$245*
D6212*	PONTIC - CAST NOBLE METAL	$245*
D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	$245*
D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	$245*
D6241*	PONTIC - PORCELAIN FUSED PREDOM BASE METAL	$245*
D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	$245*
D6243	PONTIC-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$245
D6245*	PONTIC - PORCELAIN/CERAMIC	$245*
D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	$245*
D6251*	PONTIC RESIN W/PREDOM BASE METAL	$245*
D6252*	PONTIC RESIN W/NOBLE METAL	$245*
D6253*	INTERIM PONTIC–FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	$0*
D6545	RETAINER - CASE METAL FOR RESIN FIXED PROSTHESIS	$390
D6548*	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	$225*

ADA	DESCRIPTION	MEMBER PAYS
FIXED PROSTHODONTIC SERVICES		
D6600*	RETAINER INLAY - PORCELAIN/CERAMIC 2 SURFACES	$245*
D6601*	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$245*
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	$245*
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/> SURFACES	$245*
D6604*	RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFACES	$245*
D6605*	RETAINER INLAY - CAST PREDOM BASE METAL 3/>SURFACES	$245*
D6606*	RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	$245*
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	$245*
D6608*	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	$245*
D6609*	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$245*
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURFACES	$245*
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	$245*
D6612*	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	$245*
D6613*	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	$245*
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	$245*
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	$245*
D6624*	RETAINER INLAY - TITANIUM	$245*
D6634*	RETAINER ONLAY - TITANIUM	$245*
D6710*	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$245*
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$245*
D6721*	RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	$245*
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	$245*
D6740*	RETAINER CROWN - PORCELAIN/CERAMIC	$245*
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$245*
D6751*	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$245*
D6752*	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$245*
D6753	RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$245
D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$245*
D6781*	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$245*
D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	$245*
D6783*	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$245*
D6784	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	$245
D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$245*
D6791*	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	$245*
D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	$245*
D6793*	INTERIM RETAINER CROWN–FURTHER TREATMT/COMPLT OF DIAG PRIOR TO FINAL IMPRESSION	$125*
D6794*	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	$245*
D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	$15
D6940	STRESS BREAKER	$125
D6950	PRECISION ATTACHMENT	$195
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	$80
ORAL SURGERY SERVICES		
D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	$50
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$20
D7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$30
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	$50
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	$65
D7240	REMOVAL IMPACTED TOOTH - COMPLETELY BONY	$80
D7241	REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	$135
D7250	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$40
D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL	$270
D7260	OROANTRAL FISTULA CLOSURE	$160
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$275
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	$50
D7272	TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND/OR STABILIZATION)	$100
D7280	EXPOSURE OF AN UNERUPTED TOOTH	$125
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	$125
D7283	PLACEMENT DEVICE FACILITATE ERUPT IMPACTED TOOTH	$80
D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	$125
D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	$85
D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$75
D7288	BRUSH BIOPSY	$25
D7291	TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT	$40
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$40
D7311	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	$40
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$60
D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	$60
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$370

ORAL SURGERY SERVICES

D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	$990
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	$25
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	$50
D7412	EXCISION OF BENIGN LESION, COMPLICATED	$55
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$65
D7471	REMOVAL OF LATERAL EXOSTOSIS	$95
D7472	REMOVAL OF TORUS PALATINUS	$95
D7473	REMOVAL OF TORUS MANDIBULARIS	$95
D7485	REDUCTION OF OSSEOUS TUBEROSITY	$95
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	$20
D7511	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	$20
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	$20
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	$20
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	$35
D7921	COLLECTION AND APPLICATION OF AUTOLOGOUS BLOOD CONCENTRATE PRODUCT	$125
D7950	OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR FACIAL BONES - AUTOGENOUS OR NONAUTOGENOUS, BY REPORT	$350
D7951	SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES VIA A LATERAL OPEN APPROACH	$800
D7952	SINUS AUGMENTATION VIA A VERTICAL APPROACH	$350
D7961	BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY)	$105
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	$105
D7963	FRENULOPLASTY	$105
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	$140
D7971	EXCISION OF PERICORONAL GINGIVA	$102
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	$125

ADJUNCTIVE GENERAL SERVICES

D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	$0
D9120	FIXED PARTIAL DENTURE SECTIONING	$0
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	$0
D9211	REGIONAL BLOCK ANESTHESIA	$0
D9212	TRIGEMINAL DIVISION BLOCK ANES	$0
D9215	LOCAL ANESTHESIA	$0
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	$50
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	$50
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	$20
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	$65
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	$65
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	$15
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	$25
D9430	OV OBS - NO OTH SERVICES PERFORMED	$0
D9440	OV-AFTER REGULARLY SCHEDULED HRS	$35
D9450	CASE PRSATION DTL & EXT TX PLANNING	$0
D9610	THERAPEUTIC DRUG INJECTION, BY REPORT	$15
D9630	DRUGS OR MEDICAMENTS DISPENSED IN THE OFFICE FOR HOME USE	$15
D9910*	APPLICATION OF DESENSITIZING MEDICAMENT	$20*
D9912	PRE-VISIT PATIENT SCREENING	$0
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	$0
D9932	CLEANING AND INSPECTION OF REMOVABLE COMPLETE DENTURE, MAXILLARY	$0
D9933	CLEANING AND INSPECTION OF REMOVABLE COMPLETE DENTURE, MANDIBULAR	$0
D9934	CLEANING AND INSPECTION OF REMOVABLE PARTIAL DENTURE, MAXILLARY	$0
D9935	CLEANING AND INSPECTION OF REMOVABLE PARTIAL DENTURE, MANDIBULAR	$0
D9942	REPAIR AND/OR RELINE OCCCLUSAL GUARDS	$40
D9943	OCCLUSAL GUARD ADJUSTMENT	$25
D9944*	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH	$250*
D9945*	OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH	$250*
D9946*	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH	$250*
D9947	CUSTOM SLEEP APNEA APPLIANCE FABRICATION AND PLACEMENT	$1,900
D9948	ADJUSTMENT OF CUSTOM SLEEP APNEA APPLIANCE	$85
D9949	REPAIR OF CUSTOM SLEEP APNEA APPLIANCE	$88
D9950	OCCLUSAL ANALYSIS - MOUNTED CASE	$250
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$30
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$100
D9973	EXTERNAL BLEACHING - PER TOOTH	$30
D9975	EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH	$240
D9986	MISSED APPOINTMENT	$25
D9991	DENTAL CASE MANAGEMENT - ADDRESSING APPOINTMENT COMPLIANCE BARRIERS	$0
D9992	DENTAL CASE MANAGEMENT – CARE COORDINATION	$0
D9993	DENTAL CASE MANAGEMENT – MOTIVATIONAL INTERVIEWING	$0
D9994	DENTAL CASE MANAGEMENT – PATIENT EDUCATION TO IMPROVE ORAL HEALTH LITERACY	$0
D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME ENCOUNTER	$0
D9996	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO DENTIST FOR SUBSEQUENT REVIEW	$0
D9997	DENTAL CASE MGMT-PATIENTS W/ SPECIAL NEEDS	$0

ORTHODONTIC SERVICES

D8010	LTD ORTHO TREAT OF THE PRIMARY DENTITION	$1,000
D8020	LTD ORTHO TREAT OF THE TRANS DENTITION	$1,000

ORTHODONTIC SERVICES

D8030#	LTD ORTHO TREAT OF THE ADOLESC DENTITION	$1,000#
D8040#	LTD ORTHO TREAT OF THE ADULT DENTITION	$1,350#
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION)	$2,200
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	$2,250
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	$2,350
D8210	REMOVABLE APPLIANCE THERAPY	$103
D8220	FIXED APPLIANCE THERAPY	$103
D8660	PRE-ORTHODONTIC TREATMENT EXAM TO MONITOR GROWTH AND DEVELOPMENT	$35
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	$0
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINERS)	$300
D8681	REMOVABLE ORTHODONTIC RETAINER ADJUSTMENT	$0
D8698	RECEM/REBOND FIXED RETAINER-MAXIL	$0
D8699	RECEM/REBOND FIXED RETAINER-MANDIB	$0
D8999	c UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT	$250

FixedProsthedontics

D5982*	SURGICAL STENT	$150*
D5987*	COMMISSURE SPLINT	$150*
D5988*	SURGICAL SPLINT	$150*

Additional Prophy within 6 months will be based upon the necessity recommended by the provider.

Procedure descriptions preceded with a "*" have a limitation, please see limitations below for details.

Copayment amounts with a "*" have a lab and/or materials fee in addition to the copayment amount, please see Limitations below for details.

Services with a 't' are not eligible at a Specialist.

Self-service aligners are available for a member copayment of $1000.

SPECIALTY SERVICES

a) This Member Schedule of Benefits applies when listed dental services are performed by a participating General Dentist, unless otherwise authorized.

b) Procedures not listed on the Schedule of Benefits that are perfomed by a participating General Dentist will be charged at a participating General Dentist's usual and custor less 25%.

c) This Network General Dentist you select may not perform all procedures listed. The Co-payment shown applies to Network General Dentist.

d) Should services of a Network Specialty Dentist (NSD) (Oral Surgeon, Endodontist, Periodontist, or Pediatric Dentist) be necessary, you may receive this care in two ways: 1) You may go directly to a NSD with no referral and receive a 25% reduction off the provider's Usual and Customary Fee; or 2) You may obtain prior written authorization and receive specialty treatment by an approved NSD at the listed Co-payments.

e) Should services of an Orthodontist be necessary, you may receive care in either of two ways: 1) You may go directly to a NSD with no referral and receive a 25% reduction off the provider's Usual and Customary Fee; or 2) You may contact Member Services to locate your nearest participating Orthodontist who will perform covered services at the listed member Co-payment.

f) Members seeking implant treatment should refer to their participating implantologist, a select Network of Participating Providers. Not all providers perform the implant procedures at the Co-payment listed on the Schedule of Benefits. Please refer to the provider listing at www.MyUHC.com.

UnitedHealthcare/Select Managed Care dental exclusions and limitations

LIMITATIONS OF BENEFITS

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefit

1.	BITEWING RADIOGRAPHS	D0274, D0277 or D0210 are payable only when other inclusive image have not been taken (paid) within the last six (6) months. All Bitewing X-rays are limited to one set in any twelve (12) consecutive month period.
2.	SPACE MAINTAINERS	Space maintainers and all adjustments are limited to children under the age of 16.
3.	SEALANTS	Sealants (D1351 or D1352) are limited to one (1) time per tooth in any three (3) consecutive year period. This is only allowed for unrestored permanent molar teeth for children under the age of 16.
4.	RESTORATIONS (Amalgam or Composite)	Fluoride treatment is limited to one (1) in any twelve (12) consecutive month period for children under the age of 16
5.	OCCLUSAL GUARDS	Occlusal Guard(s) is limited to one (1) time in any consecutive thirty-six (36) months for the purposes of habitual grinding/Bruxism.
6.	GENERAL ANESTHESIA	General anesthesia or IV sedation is available when listed on the Schedule of Benefits, medically necessary, and previously approved.
7.	ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS	All denture adjustment fees are for dentures which were not fabricated at the present office; All denture adjustment for new dentures made within 12 months are included as part of the initial insertion.
8.	ORAL EVALUATION	Any oral evaluation (excluding problem) is limited to One (1) time per consecutive six (6) months; Comprehensive exams can only be covered one (1) time per 36 months, if and only if patient is considered to be new or an established patient. All subsequent oral evaluations will be at a 25% reduction off the dentist's usual and customary fee without a frequency limitation.
9.	CROWNS, FIXED BRIDGES, AND IMPLANTS	When crown, implant and/or bridgework exceed six (6) consecutive units, there will be an additional charge of $30.00 per unit.
10.	THIRD-MOLAR ("WISDOM TEETH") EXTRACTIONS	Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general dentists or specialists usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the doctor's usual and customary fees.
11.	PROPHYLAXIS AND PERIODONTAL MAINTENANCE	The dental prophylaxis or periodontal maintenance procedure is limited to one (1) time in any consecutive six (6) month period. Any additional procedures will follow D1110 and D4910 Member copayments as listed in the Schedule of Benefits.
12.	HARMFUL HABIT APPLIANCES	Harmful habit appliances are limited to one (1) time per person under the age of 16.
13.	DENTURES	New dentures include one (1) reline within the first six (6) months.
14.	REPLACEMENT OF CROWNS, IMPLANTS AND FIXED BRIDGES OR DENTURES	Replacement of crowns, implants, and fixed bridges or dentures is limited to one (1) time every consecutive five (5) years.
15.	COST OF MATERIAL AND LAB FEES	Copayments marked by '*' do not include the cost of material and laboratory fees. Additional cost to patient is as follows: - High noble metal (precious) up to $145.00- Titanium metal up to $120 (covered with proof of allergy to other metals)- Noble metal (semi-precious) up to $120.00- Predominantly base metal (non-precious) up to $55.00- Crown laboratory fees up to $155.00- Laboratory fees on dentures up to $225.00- Porcelain laboratory fees for D2610-D2644, D2929, D2961, D2962, D6600, D6601, D6608, and D6609 up to $65.00- Denture repair laboratory fees up to $50.00- All ceramic and/or porcelain crown material fees up to $155.00.
16.	X-RAYS	Copies of X-rays can be obtained for $2 per periapical image up to a maximum of $30. Panoramic X-ray can be obtained for a $15 fee.
17.	EMERGENCY TREATMENT	Emergency treatment is available for palliative treatment for the abatement of pain up to $100.00 per occurrence.
18.	ORTHO	Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in cost for the enhanced treatment.
19.	RADIOGRAPHS	D0364-D0365 is limited to 1 time per 60 months, covered only in a dental setting and not in a radiographic imaging center.

EXCLUSIONS OF BENEFITS

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1.	Dental Services that are not Necessary.
2.	Hospitalization or other facility charges.
3.	Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4.	Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5.	Any Dental Procedure not directly associated with dental disease.
6.	Any Dental Procedure not performed in a dental setting.

EXCLUSIONS OF BENEFITS

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

7.	Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
9.	Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
10.	Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
11.	Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
12.	Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
13.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
14.	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.
15.	Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
16.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
17.	Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
18.	Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
19.	Foreign Services are not Covered unless required as an Emergency.
20.	Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
21.	Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
22.	Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

Language Assistance Services

We[1] provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-800-445-9090, or the toll-free member phone number listed on your dental plan ID card TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Notice of Non-Discrimination

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

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

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

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

If you need help with your complaint, please call 1-800-445-9090 or the toll-free member phone number listed on your dental plan ID card, TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m.

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

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

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

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

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

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

Claims and Appeal Notice

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

Benefit Determinations

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

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

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

Appeal Process

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

Appeals Determinations

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

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

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

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

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

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

Urgent Appeals that Require Immediate Action

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

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

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

DENTAL PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

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

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2025

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

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

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

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

How We Use or Disclose Information

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

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

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

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

- **For Health Care Operations.** We may use or disclose health information as needed to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes**. We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

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

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

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

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

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

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

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

What Are Your Rights

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

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

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

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

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

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

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

Exercising Your Rights

- **Contacting your Dental Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your dental ID card or you may call us at 1-800-445-9090, or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

  UnitedHealthcare

  Dental HIPAA - Privacy Unit

  PO Box 30567

  Salt Lake City, UT 84130

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

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

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

FINANCIAL INFORMATION PRIVACY NOTICE

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

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2025

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

Information We Collect

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

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

Disclosure of Information

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

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

Confidentiality and Security

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

Questions about this Notice

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

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

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

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

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

Receive Information about Your Plan and Benefits

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

ERISA Statement

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

Summary Plan Description

Name of Plan: Charlotte County Public Schools Welfare Benefit Plan

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

Charlotte County Public Schools

1445 Education Way
Port Charlotte, FL 33948
(727) 310-1299

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

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

Employer Identification Number (EIN): 59-6000539

Plan Number: 501

Plan Year: January 1 through December 31

Type of Plan: Health care coverage plan

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

Charlotte County Public Schools

1445 Education Way
Port Charlotte, FL 33948
(727) 310-1299

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

UnitedHealthcare
Liberty 6, Suite 200
6220 Old Dobbin Lane
Columbia, MD 21045
800-638-3895

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

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

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

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

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

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