

## **IMPORTANT NOTICE**

To obtain information or make a complaint:

You may contact United Dental Care of Texas, Inc.'s toll-free number for information or to make a complaint at

**1-800-443-2995**

You may also write to United Dental Care of Texas, Inc. at:  
13601 Preston Road, Suite 500 East, Dallas, Texas 75240

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

**1-800-252-3439**

You may write the Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104  
Fax # (512) 475-1771

### **PREMIUM OR CLAIM DISPUTES:**

Should you have a dispute concerning your premium or about a claim you should contact United Dental Care of Texas, Inc. first.

If the dispute is not resolved, you may contact the Texas Department of Insurance.

### **ATTACH THIS NOTICE TO YOUR POLICY:**

This notice is for information only and does not become a part or condition of the attached document.

## **AVISO IMPORTANTE**

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de United Dental Care of Texas, Inc. para informacion o para someter una queja al

**1-800-443-2995**

Usted tambien puede escribir a United Dental Care of Texas, Inc. at:  
13601 Preston Road, Suite 500 East, Dallas, Texas 75240

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

**1-800-252-3439**

Puede escribir al Departamento de Seguros de Texas  
P.O. Box 149104  
Austin, TX 78714-9104  
Fax # (512) 475-1771

### **DISPUTAS SOBRE PRIMAS O RECLAMOS:**

Si tiene una disputa concierne a su prima o a un reclamo, debe comunicarse con el la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

**UNA EST AVISO A SU POLIZA:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.



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## EVIDENCE OF COVERAGE

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### ARTICLE I DEFINITIONS

- 1.1 **Copayment:** Shall mean an additional fee charged to Member by Plan Provider as identified in the Copayment Schedule.
- 1.2 **Dependent:** Shall mean the spouse of any Subscriber and all newborn infants from and after the moment of birth, natural children, adopted children, grandchildren, children of whom the Subscriber has temporary or permanent court order granting conservatorship, or guardianship, and stepchildren and foster children. Adopted children are considered dependents from the date the Member becomes a party in a suit in which the adoption of the child by the member is sought, or from the date the child is placed with the member. All such children shall be under the age nineteen (19), unmarried and chiefly dependent on Subscriber for support and live in Plan Service Area. Children whose coverage is required by a medical support order issue under Texas Law-Section 14.061 Family Code, are not required to reside in the Plan Service Area. Dependents shall be eligible for coverage on the day Subscriber is eligible for coverage or on the day Subscriber acquires such Dependent, whichever is later. Eligibility may be extended up to age twenty-eight (28) for unmarried children who are financially dependent on Subscriber for maintenance and support and are registered students in regular attendance at an accredited school, college or university. Dependent shall also mean the child of Subscriber age nineteen (19) or over not capable of self-sustaining employment by reason of a disability or physical handicap and chiefly dependent on Subscriber for maintenance and support.
- 1.3 **Effective Date for a Member:** The date when coverage begins under Agreement.
- 1.4 **Emergency Services:** Shall mean bona fide emergency dental services, limited to procedures administered in a dentists office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain or acute infection that would lead a prudent lay person possessing an average knowledge of dentistry to believe that immediate care is needed.
- 1.5 **Member:** Shall mean a Subscriber or Dependent enrolled in Plan.
- 1.6 **Group:** Shall mean the employer, association, or other organization identified in Agreement.
- 1.7 **Plan Dentist:** Shall mean a General Dentist who is under contract with Plan and responsible for providing dental services to Members of Plan.
- 1.8 **Plan Provider:** Shall mean a Plan Dentist or Specialty Dentist under contract with Plan. The term shall include any hygienists and technicians recognized by the dental profession who act with and assist Plan Dentist or Specialty Dentist. Establishment and location of all Plan Providers are within the sole discretion and determination of Plan. A list of Plan Providers shall be published in Plan Dentist Directory.
- 1.9 **Specialty Dentist:** Shall mean a dentist practicing in a dental specialty under contract with Plan to provide specialty services to Members including, but not limited to, Endodontics, Orthodontics, Pedodontics, Periodontics and Oral Surgery.
- 1.10 **Plan Benefits:** Shall mean the services provided under Agreement, subject to any limitations and exclusions.

- 1.11 **Prepayment Fee:** Shall mean the monthly fee paid by Group to Plan for each Member necessary for provision of coverage.
- 1.12 **Service Area:** Shall mean all counties in the State of Texas except Brewster, Culberson, Jeff Davis, Presidio, Terrell, and Val Verde.
- 1.13 **Subscriber:** Shall mean an employee, member or beneficiary of Group who is eligible to participate in Plan under the eligibility requirements determined by Group.

#### **GLOSSARY OF DENTAL TERMS**

- 1.14 **Emergency Office Visit:** An appointment to see patient on an emergency basis during or after normal office hours.
- 1.15 **Bitewings:** X-rays that are taken to show decay between individual teeth.
- 1.16 **Panoramic X-Ray:** A large x-ray showing entire mouth, upper and lower jaws.
- 1.17 **X-Ray: Complete Series Including Bitewings:** Usually consists of 18 individual x-rays showing roots of all teeth present.
- 1.18 **Periapical X-Ray:** X-ray of certain area or tooth.
- 1.19 **Occlusal X-Ray:** An x-ray taken with a larger film, usually taken on children showing multiple teeth.
- 1.20 **Bacterial Study:** A sample of tissue or infected matter is taken from a tooth or infected area to determine the most effective antibiotics to fight the infection.
- 1.21 **Vitality Test:** A test to determine whether the nerve tissue is dead or alive using electric pulp tester, ice, or heat.
- 1.22 **Prophylaxis/Cleaning:** A polishing procedure performed usually consisting of light scraping of teeth called scaling. This procedure should be performed at least every 6 months.
- 1.23 **Fluoride Treatment:** Application of fluoride usually performed in the office on all children and some adults if they have a lot of decay. This procedure is usually performed at prophylaxis appointment.
- 1.24 **Oral Hygiene Instructions:** Home care instructions usually consisting of how to effectively brush, floss, and remove plaque from teeth and gums.
- 1.25 **Space Maintainer:** Fixed unilateral a device fabricated by a dental lab or prefabricated that is cemented on one side of the mouth to retain space from a tooth extracted or prematurely lost.
- 1.26 **Space Maintainer:** Fixed bilateral same as above except is cemented on two teeth, one on each side of the mouth.
- 1.27 **Sealant:** Per tooth a plastic like material applied to a tooth to prevent bacteria from staying in the grooves of teeth and causing decay.
- 1.28 **Pin Retention:** Per tooth a pin placed in the inner layer of a tooth to act as a supporting rod. A filling material is placed in the tooth and attaches to the pin.
- 1.29 **Amalgam:** Primary tooth also known as silver filling consisting of silver, tin, zinc, and mercury. A primary tooth is a baby tooth.
- 1.30 **Resin:** A tooth-colored filling usually comes in many shades and matched to the color of the existing teeth.
- 1.31 **Inlay/Onlay:** A filling, which is made of gold or porcelain. A mold is taken of the prepared tooth and sent to a dental lab. The lab fabricates the inlay or onlay restoration and the dentist then cements it. The cost of the gold is an additional fee to be paid by the member.

- 1.32 **Sedative Filling:** A temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.
- 1.33 **Stainless Steel Crown, Primary:** Performed on baby teeth when the decay is so extensive there is not enough tooth structure to hold a filling. This is a prefabricated crown cut and shaped to fit the tooth.
- 1.34 **Porcelain Crown:** A solid porcelain crown usually used for the front teeth. The procedure involves cutting the tooth down, taking an impression, and sending this to a dental laboratory where the crown is fabricated.
- 1.35 **Porcelain With Metal Crown:** This consists of porcelain covering the outside of the crown and baked onto a metal base, which adds strength. If gold is used as the metal, an additional charge will be made for the cost of the gold.
- 1.36 **Crown-Full Cast High Noble Metal:** A crown made of gold that covers the whole tooth. An additional charge will be made for the cost of the gold.
- 1.37 **3/4 Cast Metallic Crown:** Same as above except only approximately 3/4 of the tooth is covered. If gold is used as the metal, an additional charge will be made.
- 1.38 **Bridge:** Restoration that replaces a missing tooth or teeth by bridging the open space and securing the bridge to at least two natural teeth. The missing tooth to be replaced is called a pontic.
- 1.39 **Post And Core:** After a tooth has had a root canal it often becomes weak and a reinforcing rod or post is used for added support. The core is the material placed on the post to replace the missing tooth. This can be made either at a laboratory from an impression called cast or prefabricated from kits that the dentists have at their offices.
- 1.40 **Temporary Crown:** A crown made of plastic or a soft metal like aluminum that is placed on a tooth while the permanent is being made at a dental lab.
- 1.41 **Recement:** When an existing crown comes loose, new cement is placed in the crown which is placed over the tooth again.
- 1.42 **Core Build Up Including Pins:** When a tooth is badly broken, material is placed on the remaining tooth structure where a crown is to be placed. Sometimes metal pins are placed in the existing tooth for support.
- 1.43 **Single Tooth Extraction:** Removing a tooth.
- 1.44 **Surgical Removal of Erupted Tooth:** A more difficult removal of a tooth that involves removal of tissue to gain access to the tooth or cutting the tooth in sections to aid in the removal.
- 1.45 **Removal of Impacted Tooth-Soft Tissue:** Refers to the removal of a wisdom tooth or 3<sup>rd</sup> molar when tooth is covered partially or totally by gum tissue and involves the removal of the tissue to gain access to the tooth.
- 1.46 **Removal of Impacted Tooth-Partial Bony:** Refers to the removal of a wisdom tooth or 3<sup>rd</sup> molar when the tooth is covered by tissue as well some bone, and involves the removal of the tissue and bone to gain access to the tooth.
- 1.47 **Complete Bony Impaction:** Refers to the removal of a wisdom tooth when the tooth is completely covered by bone or lying sideways, and involves the removal of bone to gain access to the tooth.
- 1.48 **Root Removal Exposed Roots:** The removal of a root when the crown or portion of the tooth above the gum tissue is broken off and only the root is left remaining.
- 1.49 **Incision And Drainage:** The opening of an infected area to allow the infection to drain and release pressure.

- 1.50 **Surgical Exposure:** The removal of tissue to aid in the eruption of a tooth that is otherwise blocked from normal eruption.
- 1.51 **Exostosis:** An overgrowth of normal bone.
- 1.52 **Hemisection:** The surgical separation of a multi-rooted tooth.
- 1.53 **Tooth Reimplantation:** A procedure performed after an accident occurs, knocking out a permanent tooth. It involves positioning the tooth back in the socket and splinting the tooth for stabilization.
- 1.54 **Nitrous Oxide:** Otherwise known as laughing gas, is delivered through a mask worn over the nose.
- 1.55 **I.V. Sedation:** Normally used during difficult oral surgery or gum surgery procedures. The solutions are injected into the veins of the arm through a needle.
- 1.56 **Frenectomy:** Removal of the muscle attachment connecting the upper or lower lip to gum tissue if it projects between the front teeth.
- 1.57 **Direct Pulp Cap:** A sedative base applied directly to an exposed part of the pulp, in order to attempt remineralization.
- 1.58 **Indirect Pulp Cap:** A sedative base applied to a tooth in which the decay has progressed close to the pulp. This procedure is an effort to activate remineralization.
- 1.59 **Pulpotomy:** The removal of nerve tissue from the nerve chamber of the tooth.
- 1.60 **Root Canal:** The cleaning out and removal of nerve tissue from a tooth and then sealing the canal stem with a material called gutta-percha. This procedure is performed when a tooth is infected or in danger of becoming infected. Most teeth in the front of the mouth have one canal. The bicuspid have one or two canals and the molars (back teeth) have three or four canals.
- 1.61 **Apicoectomy:** Cutting off the tip of the root. This procedure is performed when the infection is so severe that root canal was not adequate to remove the infected tissue and fluid. The area around the apex of the root is also cleaned out at the same time.
- 1.62 **Retrograde Filling:** After the apicoectomy is performed, a hole remains where the apex was sectioned off and a filling is placed in this area to seal the root canal to prevent future infection.
- 1.63 **Periodontal Maintenance Procedure:** This procedure is for patients who have completed periodontal treatment (surgical and non-surgical periodontal therapies other than full mouth debridement-D4355) and includes removal of bacteria in the pocket areas, scaling and polishing of teeth, periodontal evaluation and a review of the patients plaque control efficiency.
- 1.64 **Periodontal Scaling And Root Planing:** A cleaning procedure performed which may require local anesthetic, in which the tartar and debris are cleaned from the root surface underneath the gum tissue. It is usually done in sections of the mouth called quadrants.
- 1.65 **Gingival Curettage:** Similar to above except the gums are scraped using a different dental instrument. This procedure is usually performed to delay or prevent the patient from having a more involved surgical procedure.
- 1.66 **Limited Occlusal Adjustment:** Reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the upper and lower teeth.
- 1.67 **Gingivectomy/Gingivoplasty:** Reshaping of gum tissue in an area to reduce pocket depth and allow patient to keep area clean and free of plaque.
- 1.68 **Osseous Surgery:** A surgical procedure usually performed by a periodontist. This is performed when the pocket depth is generally in the range of 6mm or greater and when there has been bone loss. The tissue is pushed away from the bone, the area is thoroughly cleaned, and the bone is recontoured, if needed. The tissue is then sutured back to reduce existing pockets.

- 1.69 **Complete Dentures, Upper or Lower:** A removable appliance that is fabricated when a person is missing all their teeth. It is made of acrylic with either porcelain or plastic teeth and fits on the bony ridge of the jaw.
- 1.70 **Immediate Denture, Upper or Lower:** A complete denture that is fabricated and placed in the mouth at the time when all the teeth are removed. It requires several relining appointments, as the sockets heal, to increase its stability. The denture usually has a full set of teeth.
- 1.71 **Partial Denture, Resin, Upper or Lower:** An appliance fabricated to replace the missing teeth on the upper or lower arch. The portion fitting on the jawbone is made of acrylic or plastic. This appliance is usually made as a temporary measure to quickly replace missing teeth.
- 1.72 **Partial-Denture, Cast Framework, Upper or Lower:** An appliance fabricated to replace missing teeth when there are still teeth present in an arch. The base or portion fitting on the jaw bone is made of a hard metal. The teeth are set in acrylic bases which fit into the framework. There are also metal clasps or bars that fit around other teeth for added support.
- 1.73 **Adjustments:** A procedure performed on existing dentures or partials to improve the fit or bit of the denture.
- 1.74 **Relines, Laboratory:** An impression material is placed inside the existing denture or partial and sent to a laboratory to remake the acrylic area touching the ridge. This is done because the ridge area has changed.
- 1.75 **Relines, Chairside:** Same as above except a soft material is placed in the acrylic base and seated in the mouth for better retention. The original base is used but a soft lining material is added to it.
- 1.76 **Tissue Conditioning, Upper or Lower:** A soft material placed inside a partial or complete denture to aid in the comfort of the appliance.

**ARTICLE II  
ELIGIBILITY AND EFFECTIVE DATE**

- 2.1 **Plan Year:** The initial Plan Year shall begin on the Effective Date and last for a period of (12) calendar months. Each subsequent Plan Year shall begin on the Anniversary Date. The Plan Year will then last for a period of twelve (12) calendar months. The Anniversary Date for this plan is September 1.
- 2.2 **Eligibility:** Subscriber and his Dependent(s) are eligible to become Members of Plan during the open enrollment period set by Group. For Subscribers who become eligible after the Effective Date, eligibility shall be subject to Groups eligibility rules and enrollment requirements. Each Member must work or live in Plan Service Area to participate in Plan with the exception of a Dependent child as defined in Section 1.2 above.

Subscriber and his Dependent(s) are eligible to become Members of Plan during the open enrollment period set by Group. A newly acquired Dependent of Subscriber shall be eligible for coverage on the day Subscriber acquires Dependent or on the day Subscriber is eligible for coverage, whichever is later. All newborn infants shall be eligible for coverage from and after the moment of birth. If an additional Prepayment Fee is required for coverage of a newborn infant, Group must notify Plan and must be paid within thirty one (31) days after the date of birth.

Prepayment Fees for other Subscribers and Dependents are addressed in Section 2.3 Coverage of Members.

- 2.3 **Coverage of Members/Effective Date:** Each Subscriber or Dependent whose Prepayment Fee has been accepted by Plan prior to the 20th day of the month will be covered beginning the first day of the following month. Each Subscriber or Dependent whose Prepayment Fee has been accepted by Plan between the 20th day and the last day of the month will be covered beginning the first day of the second following month.

**ARTICLE III  
SUBSCRIBER COPAYMENTS**

- 3.1 **Copayments:** Member shall be responsible for payment of all Copayments and charges for non-covered services. Member shall pay dental provider at the time service is rendered. Member may have an option to pay according to provider's billing procedures.

**ARTICLE IV  
BENEFITS AND COVERAGES**

- 4.1 **Assignment of Benefits:** Members coverage is intended for the sole use and benefit of Member and cannot be transferred to a third party.
- 4.2 **Plan Benefits:** Plan shall provide services to Members as set forth in the Evidence of Coverage and Copayment Schedule. Services are subject to limitations and exclusions. Services are provided for the term of Agreement. Plan reserves the right to change Plan Benefits after the initial Plan Year. Notice of such change in Plan Benefits is subject to sixty (60) days written notice prior to the renewal date.
- 4.3 **Provision of Plan Benefits/Plan Providers:** Unless there is a need for Emergency Services or Member has Specialty Benefit Rider coverage, Agreement provides only for services performed by a Plan Provider. Plan shall not have any liability due to treatment by any non-Plan dentist or physician. In addition, Plan shall not have any liability due to treatment by hospital, other person, institution or group. Each Member shall select a Plan Dentist from the Plan Dentist Directory furnished by Group to Member. Specialty services covered by Plan may be obtained from a Specialty Dentist or non-Specialty Dentist. Agreement provides for services only. This is a prepaid HMO Plan, not an insurance policy. It does not reimburse Member or Group in cash, except for (a) Emergency Services, or (b) Specialty Benefit Rider services.
- 4.4 **Selection of Provider:**
- A. **Plan Dentist:** Each Member shall select a Plan Dentist from Plan Dentist Directory. To obtain Plan Benefits, Member shall contact selected Plan Dentist.
- Change of Selected Plan Dentist:** Member or Plan Dentist may request a change of Plan Provider selection by contacting Plan. Change requests received by the 20<sup>th</sup> of the month will be effective on the 1<sup>st</sup> of the next following month. Change requests received after the 20<sup>th</sup> of the month will be effective the 1<sup>st</sup> of the second following month. Change requests may be delayed until Member pays all monies owed selected Plan Dentist. Any Member who changes selected Plan Dentist without notifying Plan shall be denied coverage for services provided by non-selected Plan Dentist.
- B. **Specialty Dentist:** If Member requires specialty services that cannot be provided by Members selected Plan Dentist, Member may obtain services from a Specialty Dentist or a non-participating Specialty Dentist. No referral is needed from selected Plan Dentist to obtain services from any Specialty Dentist. Members out-of-pocket amount will vary depending on whether services are received from a Specialty Dentist or a non-Specialty Dentist.
- 4.5 **Member/Plan Provider Relationship:** The relationship between Member and Plan Provider shall be an independent professional one. Plan Provider shall be solely responsible, without interference from Plan or Group for all services within the professional relationship between Member and Plan Provider. Plan has the right to terminate a Members coverage for failure of Member and the Plan Provider to establish a satisfactory patient-dentist relationship. Refer to Article X TERMINATION.
- 4.6 **Providers not participating with Plan:** Plan does not review practice standards of non-Plan Providers. Members who obtain services from non-Plan Providers should separately assess the practice standards and skills of those providers.

**ARTICLE V  
LIMITATIONS AND EXCLUSIONS**

1. Medical costs associated with dental procedures are not covered.
2. Plan provides for routine prophylaxis/cleanings as determined clinically necessary by your Plan Dentist.
3. The parent or guardian is responsible for affecting behavior of dependents so that provider may safely render proper dental care. Services rendered by a specialist because of behavior adjustment may affect Member's out of pocket expense. Such services needed may be physical restraint, sedation or other method of control. Such benefits may not be covered or may be limited.
4. Dentures or appliances will be replaced only after five years since dentures or appliances were provided by Plan. If denture or appliance becomes unserviceable due to illness or causes not controlled by ordinary means, the following will apply: Replacement will be made only if existing denture or appliance cannot be made serviceable.
5. Replacement of dentures, appliances or bridgework due to loss or theft is not covered.
6. Dental treatment provided or started prior to Members eligibility to receive benefits is not covered. Dental treatment started after Members termination is not covered.
7. Failure to follow prescribed treatment may result in additional charges. Accidents occurring during the course of any treatment may result in additional charges.
8. Restorations and endodontic posts and cores placed after root canal therapy are separate procedures from actual root canal treatment. Therefore, the specific co-payments listed for restorations or posts and cores will apply.
9. Orthodontic Treatment is limited as follows:
  - Minor treatment of tooth guidance/interceptive orthodontia is limited to eighteen (18) consecutive months.
  - Retention treatment is limited to eighteen (18) consecutive months. Ongoing treatment past eighteen (18) consecutive months is not covered. Also, ongoing treatment past eighteen (18) consecutive months may be subject to additional fees. This would be determined as outlined in the Copayment Schedule and determined by provider.
10. Orthodontic treatment involving therapy for myofunctional problems, T.M.J. dysfunctions, micrognathia, macroglossia, cleft palate or hormonal imbalances causing growth and developmental abnormalities, is not covered.
11. Benefits allowed for Extractions for Orthodontic purposes only are 25% less than the Plan Provider's normal retail cost.
12. Orthodontic cases, involving orthognathic surgery, are not covered.
13. Treatment for malignancies, neoplasms or cysts, including biopsy, is not covered.
14. Services provided by non-Plan dentists are not covered unless preauthorized by Plan.
15. Copayments listed for restorations do not include the cost of lab fees.
16. Restorations and splints used to increase vertical dimension, restore occlusion, or replace/stabilize tooth structure loss by attrition are not covered.
17. Fixed prosthetic restoration of six (6) or more existing teeth, when performed as a simple procedure as part of a complete oral rehabilitation or reconstruction is not covered.
18. Complete oral rehabilitation or reconstruction involving replacement of six (6) or more missing teeth using fixed prosthetic restorations and/or appliances is not covered.
19. Dental treatment is not covered if Members general health or physical limitations prevent provider from rendering appropriate dental treatment.
20. Costs associated with prescriptions or over the counter medications are not covered.
21. Implants, surgery for the insertion of implants, all related implant appliances and restorations, removable or fixed, are not covered.
22. The surgical removal of implants, or any surgery required to adjust, replace, or treat any problem related to an existing implant, or implant appliance, is not covered.
23. Plan payments for services of non-Plan providers are limited to a total of \$2,000 per calendar year.

**ARTICLE VI  
EMERGENCY SERVICES**

- 6.1 **Emergency Services:** Plan shall arrange for Emergency Services twenty four (24) hours a day, seven (7) days a week.
- A. **Inside Plan Service Area:** If Member is in Plan Service Area and needs Emergency Services, Member should do the following: Contact Members selected Plan Dentist to arrange for Emergency Services. If Members Plan Dentist is unavailable, Member may obtain Emergency Services from any licensed dentist. Plan will reimburse Member for the actual cost of Emergency Services only, subject to any Copayments, limitations and exclusions.
- B. **Outside Plan Service Area:** If Member is not in Plan Service Area and needs Emergency Services, Member should seek treatment from any licensed dentist. Plan will reimburse Member for the actual cost of Emergency Services, subject to any Copayments, limitations and exclusions.
- C. **Additional Conditions:** Reimbursement for Emergency Services provided by non-Plan dentists is subject to the following additional conditions:
1. Covered Dental services include only those necessary to relieve acute symptoms of sufficient severity. This includes severe pain, bleeding, swelling, and the like. It also includes acute symptoms of severity, which, within reason, may place Members dental health in serious jeopardy. It includes severity which may cause dysfunction of any bodily organ or part. It includes these cases of severity which last until Member can either: (1) return to Plan Service Area or (2) continue treatment with Plan Dentist.
  2. The Member must notify Plan or Plan Dentist of his condition and the service arrangements within forty-eight (48) hours after provision of Emergency Services. The Member must also return to Plan Dentist for continued services if indicated. It may happen that a Members physical condition does not allow him to notify Plan within the prescribed time. He will need to notify Plan as soon as reasonably possible.
  3. Reimbursement requests must be in writing and send to:

**Customer Service Center  
United Dental Care Texas, Inc.  
1702 East Highland Avenue, Suite 110  
Phoenix, Arizona 85016  
(800) 443-2995**

Such requests must be received by Plan within sixty (60) days of the date of service for which payment is requested. These requests must include invoices or other evidence of payment.

4. Failure to furnish proof within the required time shall not nullify or reduce claim. This applies if it was not reasonably possible to give proof within the required time. This is true provided proof is furnished as soon as reasonably possible.
5. If Emergency Services are performed at a hospital or outpatient care facility other than a dentists office, Plan shall pay only applicable dental charges.

**ARTICLE VII  
DENTAL CHARGES PAID BY MEMBERS**

- 7.1 Member shall furnish Plan written proof that Member paid provider for covered benefits and services. Plan may reimburse Member. If so it will be without prejudice to Plans right to seek recovery of any payment made by Plan. Requests for reimbursement must be in writing and sent to:

**Customer Service Center  
United Dental Care of Texas, Inc.  
1702 East Highland Avenue, Suite 110  
Phoenix, Arizona, 85016  
(800) 433-2995**

Such requests must include invoices describing services provided.

- A. Proof of Charges. If Member is charged for covered benefits, written proof of charges must be furnished to Plan. This must be within sixty (60) days after receipt of benefit. Plan will acknowledge receipt of proof of charges within the following fifteen (15) days of receipt.
- B. Failure to Furnish Proof of Charges. Failure to furnish proof to Plan within the required time shall not nullify or reduce reimbursement. This is true: (1) only if it was not reasonably possible to provide proof within such time and (2) if proof is furnished as soon as reasonably possible.
- C. Reimbursement of Charges. Reimbursement requests for a completed claim will be processed within forty-five (45) days of receipt of request by Plan. This applies unless Member is notified of the need for additional time. If reimbursement is denied, in part or in full, written notice shall be given to Member within 45 days of receipt of request. Such notice will contain the reasons for denial.
- D. Review. Member may obtain a review of the denial through Plans Member Appeals Process.
- E. Limitations of Actions.
  - 1. No action at law or equity shall be brought under this Section against Plan prior to the end of a ninety (90) day period. This ninety (90) day period follows the date on which written proof of the charge or loss has been furnished to Plan, or later than three (3) years after the ending of the period of time in which such proof of charge or loss must be furnished to Plan.
  - 2. No liability shall be imposed upon Plan other than for benefits covered herein.

**ARTICLE VIII  
COORDINATION OF BENEFITS**

- 8.1 **Coordination of Benefits:** Is the process for determining payment responsibility in cases where Member has benefit coverage with more than one carrier. The primary plan is the plan whose coverage applies first. The secondary plan may provide additional benefits after the primary benefits are applied.

Plan is primary under the following conditions:

- 1. If Member has coverage under more than one licensed HMO plan, the plan that covers the individual as Member or Subscriber of Group is primary.
- 2. If Member has coverage under both a licensed HMO plan and an indemnity plan, the HMO plan is primary.
- 3. In the case of covered Dependents who are not directly covered under a Group plan, the plan of the parent whose birthday occurs earliest in the year (not the one who is oldest) is primary.

The above may not apply in the case of a divorce decree, court action or the like in compliance with Texas Department of Insurance Regulations, which may mandate that other coverage be primary.

Managed care is not insurance. Therefore, coordination of benefits does not apply as in the typical insurance setting. When Plan is primary and an indemnity plan is secondary, Member pays any applicable copayment at the time of service. Member may then file a claim for the out of pocket copayment amount with the indemnity carrier, who would then reimburse Member a percentage of the copayment amount(s) paid according to the provisions of their indemnity plan.

When an indemnity plan is primary, the individual either files a claim for the out of pocket expense with the indemnity plan, or assigns reimbursement to the dentist. The indemnity plan will reimburse either Member or dentist according to the provisions of the indemnity plan. After reimbursement is made, any remaining balance is the responsibility of Member.

Plan may be of benefit to Member, in addition to primary indemnity coverage, by limiting Members expense to the amount of the copayment under Plan. When the indemnity plan deductible has been met, Plan, as secondary, may put an upper limit on Members out of pocket expense based on the Copayment Schedule. Payment to the dentist in such case would be the greater of the amount paid by the indemnity plan, or the amount paid by the indemnity plan plus an amount from Member. This process brings the total payment to dentist to the proper Plan copayment amount.

## **ARTICLE IX MEMBER APPEALS PROCESS**

- 9.1 **Resolution Procedures:** Any inquiry, complaint or grievance shall be made by contacting Plan or Plan Provider. Members should take any question or concern directly to Plan Provider rendering service to resolve the issue immediately. Plan inquiries or dissatisfactions may be conveyed by telephone or in writing.

**Definition:** A complaint is defined as any dissatisfaction, expressed by Member orally or in writing to Plan regarding any aspect of the companys operation. This includes dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination; the denial, reduction or termination of a service; the way a service is provide; or disenrollment decisions. An adverse determination is a determination by Plan that the dental care services furnished or proposed to be furnished are not dentally necessary or appropriate.

- A. **Verbal Complaint:** Member may contact Plan Customer Service department regarding any inquiry, complaint or grievance that cannot be resolved to Members satisfaction. This occurs after speaking directly with the dentist or other concerned party. Plan Customer Service Representative will assess and resolve Members concern. If Member is not satisfied with the resolution, Member may file a written complaint to Plan. Plan Customer Service Representative will provide Member with the guidelines. In addition, such representative will provide complaint form to be completed.
- B. **Written Complaint:** Plan expects receipt of a completed complaint form or correspondence from Member expressing dissatisfaction with service or care delivered by Plan or Plan Dentist. Once this occurs, Plan will acknowledge the written complaint within five (5) business days. Plan will investigate the complaint and will provide a written resolution to Member within (30) calendar days. In matters of quality of care or clinical issues, an appropriate health professional will be consulted. If the complaint is not resolved to Members satisfaction, Plan shall provide an appeal procedure.
- C. **Appeal Procedure:** If Member is not satisfied with the resolution of a written complaint, Member may request an appeal of Plans assessment by submitting a written request to Plan within thirty (30) days after receipt of the written resolution. Within five (5) days of receipt, Plan will send Member an acknowledgement of receipt of Members request for appeal which shall include information regarding the appeal process and Members right to appear before the appeal panel. Plan will conduct an investigation of the appeal involving persons who did not participate in the initial resolution of the Written Complaint. In matters concerning quality of care, an appropriate health care professional will be consulted. At the conclusion of the investigation, Plan will notify Member of Plans decision. In all cases, the Member will receive written notice containing the final determination of the appeal panel. The notice shall include the specific dental judgement and/or contractual criteria used to reach the final decision and the address and toll-free number of the Texas Department of Insurance. The appeals process shall be completed within thirty (30) days after receipt of Members request for appeal.

- D. Complaints Regarding Emergency Services: Notwithstanding any provision on the Agreement to the contrary, investigation and resolution of complaints regarding presently occurring Emergency Services shall be concluded in accordance with the immediacy of the case and shall not exceed twenty-four (24) hours from the Members complaint.

## ARTICLE X TERMINATION

- 10.1 **Termination of Eligibility:** If Subscriber is terminated or leaves Group, Subscriber and his Dependents shall continue to be covered until Plan is notified in writing of Subscribers termination.
- 10.2 **Member Termination:** Member coverage shall terminate as follows:
- A. On the last day of the month for which Group has placed Member on eligibility list and paid the proper Prepayment Fee.
  - B. If Member ceases to meet eligibility requirements of Group, coverage will terminate on the next Prepayment Fee due date, subject to the individual conversion privilege, if available.
  - C. If Member commits fraud or material misrepresentation in the use of services or facilities, coverage for Member will terminate upon fifteen (15) days written notice of termination.
  - D. If Member commits fraud or material misrepresentation on the Enrollment Form, coverage will terminate upon fifteen (15) days written notice of termination. This provision will not be enforced after two (2) years from the time Members coverage began.
  - E. If Group or Plan terminates Agreement, coverage for Member shall cease on the termination date. This shall be subject to any notice required by state law.
  - F. If Member fails to make required payments, Plan reserves the right to terminate coverage upon sixty (60) days written notice. Such payments include Copayments and missed appointment fees. Prepayment Fees received for terminated Member for the period after termination date shall be refunded to Group. Thereafter, Plan shall have no further liability or responsibility to Member.
  - G. A Member, after reasonable efforts, may be unable to establish a satisfactory dentist-patient relationship with a Plan Provider. If so, Plan reserves the right to terminate coverage upon sixty (60) days written notice. Prepayment Fees received for terminated Member for the period after termination date shall be refunded to Group. Thereafter, Plan shall have no further liability or responsibility to Member.
  - H. Coverage for Subscribers Dependents will be terminated if the coverage for Subscriber terminates for any reason. This is subject to continuation privileges for certain Dependents as set forth herein.
  - I. Once a Member is no longer qualified as a Dependent, coverage for that Member will terminate. Coverage shall not terminate while a Dependent child of Subscriber is and continues to be incapable of self-sustaining employment. This is by reason of a disability or physical handicap. Dependent must be chiefly dependent on the Subscriber for maintenance and support. Subscriber must furnish proof of incapacity and dependency to Plan. This must occur within thirty-one (31) days of the child attaining limiting age. This also must occur every year thereafter, if requested by Plan.
  - J. A Member may have fulfilled his obligations under Plan for one (1) year. If so, Member may elect to terminate coverage by giving thirty (30) days written notice to Group.
  - K. If Member no longer works or lives in Plan Service Area, coverage will terminate upon thirty (30) days written notice of termination. This does not apply to a Dependent child under a medical support order as defined in the Dependent Section 1.2 of this Agreement.
  - L. Upon misconduct detrimental to safe plan operations and the delivery of services, Members coverage may be cancelled immediately.

**ARTICLE XI  
CONTINUATION OF COVERAGE / CONVERSION / COBRA**

11.1 **Continuation of Coverage:** If Agreement is terminated, each Plan Provider shall complete all dental procedures started prior to the date of termination. This is pursuant to the terms of Agreement and as required by state law, except for orthodontia treatment. Should a Member in orthodontia treatment terminate for any reason, Member shall be responsible for payment of services rendered after the termination date.

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

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

11.2 **Conversion Privilege:** If Member ceases to meet eligibility requirements of Group, Member may convert to an individual dental plan. This occurs without furnishing evidence of insurability. In order to obtain an individual dental plan, Member must work or live in Plan Service Area. However, a Dependent child covered by the Plan pursuant to a court order is not required to work or reside in the Plan Service Area, but within the United States, for the purposes of accessing this conversion privilege. The Member must submit a completed individual enrollment form and all Prepayment Fees to Plan within thirty-one (31) days after termination date. Plan will notify Member in writing of coverage effective date. Conversion privileges shall not be made available to Member terminated as a result of fraud or material misrepresentation.

11.3 **Continuation of Coverage under COBRA:** If under the provisions of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99-272, Member is granted the right to continue coverage beyond the date Members coverage would otherwise terminate, the following applies. Agreement shall be deemed to allow coverage to continue to comply with the provisions of applicable statutes. Member should contact Group concerning eligibility.

**ARTICLE XII  
GENERAL PROVISIONS**

12.1 **Amendments or Riders:** By mutual consent, Plan and Group may modify, amend or alter Agreement. Such change shall be in writing and duly executed by both parties. Any change shall be attached to Agreement. Plan may amend Agreement unilaterally to comply with germane law.

- 12.2 **Distribution of Plan Materials and Notices to Members:** Plan may be obligated under state law to give notice or Plan materials to Member. If so, it shall be sufficient for Plan to give notice or Plan materials to the Groups delegate, unless state law requires otherwise. Group shall then be responsible for providing notice or Plan materials to Subscribers.
- 12.3 **Circumstances Beyond Plans Control:** Rendition of dental services may be delayed or made impractical due to circumstances not within Plans control. If this occurs, neither Plan nor Plan Provider shall have any liability or obligation to provide services on account of such delay. This includes, but is not limited to, complete or partial destruction of facilities, war, riot, and civil insurrection. It also includes labor disputes or disability of a significant number of Plan Providers.
- 12.4 **Major Disaster or Epidemic:** If a major disaster or epidemic occurs, Plan Provider shall render dental services as practical according to his judgment. Such disaster or epidemic may limit available facilities or personnel. In such situation, neither Plan nor Plan Provider shall have any liability or obligation for delay or failure to provide dental services.

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

# Copayment Schedule with Specialty Benefits

Benefits provided by UNITED DENTAL CARE OF TEXAS, INC. 16775 Addison Road, Suite 500 Addison, TX 75001 800-433-2995

## 1. PLAN DENTIST SERVICES (subject to Limitations and Exclusions listed in the Evidence of Coverage):

The dental services listed on the Copayment Schedule below are covered only when provided by Member's selected Plan Dentist. Dental services that do not appear on this list are not covered by Plan. Member will be responsible for paying the amount listed in "Member Copayment" column at the time the service is received, or in accordance with Plan Dentist's billing procedures.

**Except in the case of Covered Dental Emergency Services, payment for all services received from a non-Plan Dentist will be the responsibility of the Member, unless otherwise authorized by Plan in writing.**

ADA Code	Service Description **	Member Copayment
<b>Appointments</b>		
120	Periodic oral evaluation	No Charge
140	Limited oral evaluation, problem focused	20.00
150	Comprehensive oral evaluation - new or established patient	No Charge
180	Comprehensive periodontal evaluation - new or established patient	No Charge
9440	Office visit - after regularly scheduled office hours	40.00
None	Office visit during regularly scheduled hours***	5.00
<b>Diagnostic Dentistry</b>		
210	X-Ray: intraoral - complete series (including bitewings)	No Charge
220	X-Ray: intraoral - periapical first film	No Charge
230	X-Ray: intraoral - periapical each additional film	No Charge
240	X-Ray: intraoral - occlusal film	No Charge
250	X-Ray: extraoral - first film	No Charge
260	X-Ray: extraoral - each additional film	No Charge
270	X-Ray: bitewing - single film	No Charge
272	X-Ray: bitewing - two films	No Charge
274	X-Ray: bitewing - four films	No Charge
330	X-Ray: panoramic film	5.00
415	Bacterial studies for determination of pathologic agents	No Charge
425	Caries susceptibility tests	No Charge
460	Pulp vitality tests	No Charge
<b>Preventive Dentistry</b>		
1110	Prophylaxis - adult (once every 6 mos.)	No Charge
1120	Prophylaxis - child up to age 18 (once every 6 mos.)	No Charge
1203	Topical application of fluoride - child up to age 18 (prophylaxis not included)	No Charge
1310	Nutritional counseling for control of disease	No Charge
1330	Oral hygiene instructions	No Charge
1351	Sealant - per tooth	7.00
1510	Space maintainer - fixed - unilateral*	60.00
1515	Space maintainer - fixed - bilateral*	60.00
1520	Space maintainer - removable - unilateral*	65.00
1525	Space maintainer - removable - bilateral*	70.00
1550	Re-cementation of space maintainer	15.00
None	Additional prophylaxis*** (Additional prophylaxis does not apply to patients with periodontal disease)	25.00

ADA Code	Service Description **	Member Copayment
<b><u>Restorative Dentistry (Fillings/Crowns)</u></b>		
2140	Amalgam - one surface, primary or permanent	9.00
2150	Amalgam - two surfaces, primary or permanent	12.00
2160	Amalgam - three surfaces, primary or permanent	14.00
2161	Amalgam - four or more surfaces, primary or permanent	18.00
2330	Resin-based composite - one surface, anterior	15.00
2331	Resin-based composite - two surfaces, anterior	20.00
2332	Resin-based composite - three surfaces, anterior	25.00
2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	40.00
2391	Resin-based composite - one surface, posterior	30.00
2392	Resin-based composite - two surfaces, posterior	45.00
2393	Resin-based composite - three surfaces, posterior	65.00
2394	Resin-based composite - four or more surfaces, posterior	65.00
2510	Inlay - metallic - one surface*	80.00
2520	Inlay - metallic - two surfaces*	90.00
2530	Inlay - metallic - three or more surfaces*	115.00
2543	Onlay - metallic - three surfaces*	185.00
2544	Onlay - metallic - four or more surfaces*	185.00
2610	Inlay - porcelain/ceramic - one surface*	190.00
2620	Inlay - porcelain/ceramic - two surfaces*	195.00
2630	Inlay - porcelain/ceramic - three or more surfaces*	195.00
2740	Crown - porcelain/ceramic substrate*	235.00
2750	Crown - porcelain fused to high noble metal*	235.00
2751	Crown - porcelain to predominantly base metal*	235.00
2752	Crown - porcelain fused to noble metal*	235.00
2790	Crown - full cast high noble metal*	235.00
2791	Crown - full cast predominantly base metal*	235.00
2792	Crown - full cast noble metal*	235.00
2910	Recement inlay	15.00
2920	Recement crown	15.00
2930	Prefabricated stainless steel crown - primary tooth	60.00
2940	Sedative filling	7.00
2950	Core buildup, including any pins	50.00
2951	Pin retention - per tooth, in addition to restoration	15.00
2952	Cast post and core in addition to crown*	80.00
2954	Prefabricated post and core in addition to crown	75.00
2960	Labial veneer (laminare) - chairside	200.00
2962	Labial veneer (porcelain laminare) - laboratory*	315.00
2980	Crown repair, by report*	25.00
None	Temporary filling***	15.00
None	Cosmetic bleaching, per arch***	150.00
None	Cosmetic bleaching, both arches***	250.00
<b><u>Endodontics (Root Canals)</u></b>		
3110	Pulp cap - direct (excluding final restoration)	5.00
3120	Pulp cap - indirect (excluding final restoration)	5.00
3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	25.00
3310	Root canal therapy: anterior (excluding final restoration)	95.00
3320	Root canal therapy: bicuspid (excluding final restoration)	165.00
3330	Root canal therapy: molar (excluding final restoration)	175.00
3346	Retreatment of previous root canal therapy - anterior	320.00
3347	Retreatment of previous root canal therapy - bicuspid	380.00

<b>ADA Code</b>	<b>Service Description **</b>	<b>Member Copayment</b>
3348	Retreatment of previous root canal therapy - molar	455.00
3410	Apicoectomy/periradicular surgery - anterior	100.00
3421	Apicoectomy/periradicular surgery - bicuspid (first root)	110.00
3425	Apicoectomy/periradicular surgery - molar (first root)	115.00
3426	Apicoectomy/periradicular surgery (each additional root)	85.00
3430	Retrograde filling - per root	35.00
3450	Root amputation - per root	65.00
3920	Hemisection (including any root removal), not including root canal therapy	60.00
<b><u>Periodontics</u></b>		
4210	Gingivectomy or gingivoplasty - 4+ contiguous or bounded teeth spaces per quadrant	90.00
4211	Gingivectomy or gingivoplasty - 1 to 3 teeth, per quadrant	54.00
4260	Osseous surgery (including flap entry and closure) 4+ contiguous or bounded teeth spaces per quadrant	200.00
4261	Osseous surgery (including flap entry and closure) 1 to 3 teeth per quadrant	120.00
4320	Provisional splinting - intracoronal	65.00
4321	Provisional splinting - extracoronal	55.00
4341	Periodontal scaling and root planing, 4+ contiguous or bounded teeth spaces per quadrant	35.00
4342	Periodontal scaling and root planing, one to three teeth per quadrant	21.00
4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	25.00
4910	Periodontal maintenance	30.00
None	Periodontal hygiene instructions***	No Charge
None	Periodontal charting for planning treatment of periodontal disease***	8.00
<b><u>Removable Prosthodontics (Dentures)</u></b>		
5110	Complete denture - maxillary*	295.00
5120	Complete denture - mandibular*	295.00
5130	Immediate denture - maxillary*	355.00
5140	Immediate denture - mandibular*	355.00
5211	Maxillary partial denture - resin base*	295.00
5212	Mandibular partial denture - resin base*	295.00
5213	Maxillary partial denture - cast metal framework with resin denture bases*	350.00
5214	Mandibular partial denture - cast metal framework with resin denture base* (5211 - 5214 includes any conventional clasps, rests, and teeth)	350.00
5410	Adjust complete denture - maxillary	10.00
5411	Adjust complete denture - mandibular	10.00
5421	Adjust partial denture - maxillary	10.00
5422	Adjust partial denture - mandibular	10.00
5510	Repair broken complete denture base*	25.00
5610	Repair resin denture base*	35.00
5620	Repair cast framework*	35.00
5630	Repair or replace broken clasps	35.00
5640	Repair broken teeth - per tooth	35.00
5650	Add tooth to existing partial denture	35.00
5730	Reline complete maxillary denture (chairside)	60.00
5731	Reline complete mandibular denture (chairside)	60.00
5740	Reline maxillary partial denture (chairside)	60.00
5741	Reline mandibular partial denture (chairside)	60.00
5750	Reline complete maxillary denture (laboratory)*	95.00
5751	Reline complete mandibular denture (laboratory)*	95.00
5760	Reline maxillary partial denture (laboratory)*	95.00
5761	Reline mandibular partial denture (laboratory)*	95.00
5850	Tissue conditioning, maxillary	25.00
5851	Tissue conditioning, mandibular	25.00

ADA Code	Service Description **	Member Copayment
5862	Precision attachment, by report*	100.00
<b><u>Fixed Prosthodontics</u></b>		
6210	Pontic - cast high noble metal*	235.00
6211	Pontic - cast predominantly base metal*	235.00
6212	Pontic - cast noble metal*	235.00
6240	Pontic - porcelain fused to high noble metal*	235.00
6241	Pontic - porcelain fused to predominantly base metal*	235.00
6242	Pontic - porcelain fused to noble metal*	235.00
6251	Pontic - resin with predominantly base metal*	235.00
6545	Retainer - cast metal for resin bonded fixed prosthesis*	110.00
6721	Crown - resin with predominantly base metal*	235.00
6750	Crown - porcelain fused to high noble metal*	235.00
6751	Crown - porcelain fused to predominantly base metal*	235.00
6752	Crown - porcelain fused to noble metal*	235.00
6780	Crown - 3/4 cast high noble metal*	235.00
6790	Crown - full cast high noble metal*	235.00
6791	Crown - full cast predominantly base metal*	235.00
6792	Crown - full cast noble metal*	235.00
6930	Recement fixed partial denture	15.00
6940	Stress breaker	150.00
6950	Precision attachment, by report	150.00
6980	Fixed partial denture repair, by report*	45.00
None	Resin bonded bridge pontic, per unit*** (*)	235.00
<b><u>Oral Surgery</u></b>		
7111	Extraction, coronal remnants - deciduous tooth	9.00
7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	9.00
7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	30.00
7220	Removal of impacted tooth - soft tissue	40.00
7230	Removal of impacted tooth - partially bony	60.00
7240	Removal of impacted tooth - completely bony	70.00
7241	Removal of impacted tooth - completely bony, with unusual surgical complications	80.00
7250	Surgical removal of residual tooth roots (cutting procedure)	30.00
7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	65.00
7281	Surgical exposure of impacted or unerupted tooth to aid eruption	50.00
7310	Alveoloplasty in conjunction with extractions - per quadrant	35.00
7320	Alveoloplasty not in conjunction with extractions - per quadrant	50.00
7471	Removal of lateral exostosis - maxillary and mandibular	70.00
7510	Incision and drainage of abscess intraoral soft tissue	25.00
7910	Suture of small wound up to 5 centimeters	5.00
7960	Frenulectomy (frenectomy or frenotomy) separate procedure	40.00
<b><u>Other Services</u></b>		
9220	Deep sedation/general anesthesia - first 30 minutes	180.00
9230	Analgesia, anxiolysis, inhalation of nitrous oxide - per 30 minutes	8.00
9241	Intravenous conscious sedation/analgesia - first 30 minutes	180.00
9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	30.00
9940	Occlusal guards, by report	85.00
9951	Occlusal adjustment - limited	20.00
9952	Occlusal adjustment - complete	110.00

**2. SPECIALIST SERVICES(subject to Limitations and Exclusions listed in the Evidence of Coverage):** Should Member require dental services that his selected Plan Dentist is unable to provide, he may obtain those services from a Plan Specialist or a non-Plan Specialist. No referral is needed from the selected Plan Dentist in order for Member to obtain services from the specialist of his choice. However, Members out-of-pocket amount may vary depending on whether services are received from a Plan Specialist or a non-Plan Specialist. Member responsibilities for obtaining services under either method are outlined below.

**A1. Plan Specialist Services on Copayment Schedule(subject to Limitations and Exclusions listed in the Evidence of Coverage):** The following Copayment Schedule applies to covered services when they are provided by a Plan Specialist. If Member receives a service listed on the schedule, he will be responsible for paying the amount in Member Copayment column at the time the service is received, or in accordance with Plan Specialists billing procedures.

<b>ADA Codes</b>	<b>Service Description</b>	<b>Member Copayment</b>
0140	Limited oral evaluation, problem focused	25.00
0150	Comprehensive oral evaluation, problem focused	25.00
3320	Root canal therapy: bicuspid (excluding final restoration)	235.00
3330	Root canal therapy: molar (excluding final restoration)	320.00
3346	Retreatment of previous root canal therapy - anterior	335.00
3347	Retreatment of previous root canal therapy - bicuspid	430.00
3348	Retreatment of previous root canal therapy - molar	475.00
3410	Apicoectomy/periradicular surgery - anterior	200.00
3421	Apicoectomy/periradicular surgery - bicuspid, first root	230.00
3425	Apicoectomy - Molar, First Root	265.00
3430	Retrograde filling - per root	65.00
4210	Gingivectomy or gingivoplasty Four + teeth, per quadrant	225.00
4211	Gingivectomy or gingivoplasty - 1 to 3 teeth, per quadrant	135.00
4260	Osseous Surgery (including flap entry and closure) 4+ teeth per quadrant	390.00
4261	Osseous Surgery (including flap entry and closure) 1 to 3 teeth per quadrant	234.00
4341	Periodontal scaling and root planing, 4+ teeth per quadrant	80.00
4342	Periodontal scaling and root planing, 1 to 3 teeth per quadrant	48.00
4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	55.00
4381	Local delivery of chemotherapeutic agents, per tooth	60.00
7210	Surgical removal of erupted tooth	60.00
7220	Removal of impacted tooth - soft tissue	80.00
7230	Removal of impacted tooth - partial bony	105.00
7240	Removal of impacted tooth - complete bony	150.00
7241	Removal of impacted tooth - complete bony with complications	160.00
7250	Surgical removal of residual tooth roots (cutting procedure)	60.00
7281	Surgical exposure of impacted or unerupted tooth to aid eruption	150.00
7310	Alveoloplasty in conjunction with extractions - per quadrant	100.00
7320	Alveoloplasty not in conjunction with extractions - per quadrant	85.00
7471	Removal of lateral exostosis maxillary or mandibular	220.00
7510	Incision and drainage of abscess intraoral soft tissue	70.00
7960	Frenectomy (frenectomy or frenotomy) separate procedure	145.00
9241	Intravenous conscious sedation/analgesia, first 30 minutes	130.00

**A2. Plan Specialist Services not on Copayment Schedule(subject to Limitations and Exclusions listed in the Evidence of Coverage):** Dental services obtained from a Plan Specialist, but not listed on the schedule above, will be provided to Member at a discount. A 15% discount, off that Plan Specialists normal retail charges, will be applied to services obtained from a Plan Specialist who is an Endodontist. A 25% discount, off that Plan Specialists normal retail charges, will be applied to all other services (including orthodontic services) received from a Plan Specialist. Member will be responsible for paying the discounted charge at the time the services is received, or in accordance with Plan Specialists billing procedures.

**B1. Specialist Services received from a non-Plan Specialist on Copayment Schedule**(subject to a \$2,000.00 limit paid by Plan in any calendar year)(subject to Limitations and Exclusions listed in the Evidence of Coverage): If a Member chooses to receive a dental service listed on the following schedule from a non-Plan Specialist, he will be responsible for paying that specialist's entire normal retail charge for the service at the time the service is received or in accordance with specialist's billing procedures. Member may then submit a completed claim form, with an itemized bill attached, to Plan (Member may obtain claim forms by contacting Plan.) Plan will pay Member lesser of the amount shown in Plan Payment column of the following schedule or the amount charged by specialist for the service.

ADA Codes	Service Description	Plan Payment
0140	Limited oral evaluation, problem focused	15.00
0150	Comprehensive oral evaluation, problem focused	15.00
3320	Root canal therapy: bicuspid (excluding final restoration)	265.00
3330	Root canal therapy: molar (excluding final restoration)	330.00
3346	Retreatment of previous root canal therapy - anterior	215.00
3347	Retreatment of previous root canal therapy - bicuspid	220.00
3348	Retreatment of previous root canal therapy - molar	300.00
3410	Apicoectomy/periradicular surgery - anterior	250.00
3421	Apicoectomy/periradicular surgery - bicuspid, first root	350.00
3425	Apicoectomy - Molar, First Root	335.00
3430	Retrograde filling - per root	60.00
4211	Gingivectomy or gingivoplasty - 1 to 3 teeth, per quadrant	75.00
4260	Osseous Surgery (including flap entry and closure) 4+ teeth per quadrant	310.00
4261	Osseous Surgery (including flap entry and closure) 1 to 3 teeth per quadrant	186.00
4341	Periodontal scaling and root planing, 4+ teeth per quadrant	70.00
4342	Periodontal scaling and root planing, 1 to 3 teeth per quadrant	42.00
4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	35.00
4381	Local delivery of chemotherapeutic agents, per tooth	40.00
7210	Surgical removal of erupted tooth	90.00
7220	Removal of impacted tooth - soft tissue	95.00
7230	Removal of impacted tooth - partial bony	120.00
7240	Removal of impacted tooth - complete bony	100.00
7241	Removal of impacted tooth - complete bony with complications	130.00
7250	Surgical removal of residual tooth roots (cutting procedure)	100.00
7281	Surgical exposure of impacted or unerupted tooth to aid eruption	110.00
7310	Alveoloplasty in conjunction with extractions - per quadrant	40.00
7320	Alveoloplasty not in conjunction with extractions - per quadrant	100.00
7471	Removal of lateral exostosis maxillary or mandibular	140.00
7510	Incision and drainage of abscess intraoral soft tissue	35.00
7960	Frenulectomy (frenectomy or frenotomy) separate procedure	115.00
9241	Intravenous conscious sedation/analgesia, first 30 minutes	100.00

**B2. Not on Copayment Schedule:** Any service that is both (a) received from a non-Plan Specialist and (b) not listed on the schedule above will not be covered by plan. The entire charge for the service will be the responsibility of Member.

\* Member will be responsible for cost of additional lab fees for these services.

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

\*\*\* Current and prior versions of the current dental terminology (CDT) dental procedure codes (in the ADA Code column) and nomenclatures and/or descriptors (in the Service Description column) are copyrighted by the American Dental Association (ADA) and are used by permission. Copyright 1991, 1994, 2002 American Dental Association.

## HIPAA NOTICE OF PRIVACY PRACTICES

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

### I. Our Commitment

Fortis Benefits and its affiliates\* are committed to protecting the personal information entrusted to us by our customers. The trust you place in us when you share your personal information is a responsibility we take very seriously and is the cornerstone of how we conduct our business.

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

### II. Our Use and Disclosure of Your PHI

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

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

- Underwriting our risk and determining rates and premiums for your dental or vision plan;
- Determining your eligibility for benefits;
- Reviewing the competence and qualifications of dental care or other providers;
- Conducting or arranging for dental review, legal services, and auditing functions, including fraud and abuse detection and compliance;
- Business planning and development;
- Business management and general administrative duties such as cost-management, customer service, and resolution of internal grievances;
- Other administrative purposes.
- We can also make disclosures under the following circumstances without your permission:
- As required by law, including response to court and administrative orders, or to report information about suspected criminal activity;

- To report abuse, neglect, or domestic violence;
- To authorities that monitor our compliance with these privacy requirements;
- To coroners, medical examiners, and funeral directors;
- For research and public health activities, such as disease and vital statistic reporting;
- To avert a serious threat to health or safety;
- To the military, certain federal officials for national security activities, and to correctional institutions;
- To the entity sponsoring your group dental or vision plan but only for purposes of enrollment, disenrollment, and eligibility. We also are allowed to give the plan sponsor summary information when necessary to help make decisions regarding changes to the plan;
- To a spouse, family member, or other personal representative if they can show they are assisting in your care or payment of your care and then, without an authorization, only basic information about the status or payment of a claim.

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

### III. Your Individual Rights

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

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

a charge for accounting disclosures if requested more than once a year.

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

#### IV. Who to Contact for Questions and Complaints

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

Mailing Address:	Fortis Benefits Insurance Company Privacy Office P.O. Box 419052 Kansas City, MO 64141-6052
Telephone	(800) 733-7879
Email	Mail to: <a href="mailto:PrivacyOffice.FBIC@us.fortis.com">mailto:PrivacyOffice.FBIC@us.fortis.com</a>
Web Site	<a href="http://www.fortisbenefits.com/">http://www.fortisbenefits.com/</a>

#### V. Organizations Covered by This Notice

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

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

\* In this notice, we, us, and our refer to Fortis Benefits Insurance Company; and the following Fortis Benefits DentalCare companies: UDC Life and Health Insurance Company; United Dental Care of Missouri, Inc.; DentiCare of Oklahoma, Inc.; DentiCare of Alabama, Inc.; DentiCare of Arkansas, Inc.; DentiCare, Inc. (A Florida Corporation) A Prepaid Limited Health Service Organization Licensed Under Chapter 636 of the Florida Statutes; DentiCare, Inc. (A Kentucky Corporation); Georgia Dental Plan, Inc.; International Dental Plans, Inc.; Fortis Benefits DentalCare of Wisconsin, Inc.; Fortis Benefits DentalCare of New Jersey, Inc.; UDC Dental California, Inc. dba United Dental Care of California, Inc.; UDC Ohio, Inc. dba United Dental Care of Ohio, Inc.; United Dental Care of Arizona, Inc.; United Dental Care of Colorado, Inc.; United Dental Care of Indiana, Inc.; United Dental Care of Michigan, Inc.; United Dental Care of Nebraska, Inc.; United Dental Care of New Mexico, Inc.; United Dental Care of Pennsylvania, Inc.; United Dental Care of Texas, Inc.; United Dental Care of Utah, Inc.; and United Dental Care Insurance Company.