

**UDC Dental California, Inc.  
621 Capitol Mall, Suite 900  
Sacramento, CA 95814**

**(800-443-2995)**

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**COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM**

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**INTRODUCTION TO PLAN**

UDC Dental California, Inc. (the "Plan") is a prepaid specialized dental plan licensed by the State of California. The Plan has a panel of general and specialty dentists who are available to provide necessary covered dental services to the Plan's Members.

**This Combined Evidence of Coverage and Disclosure Form ("EOC" or Evidence of Coverage and Disclosure Form) discloses the terms and conditions of coverage. You have a right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment in this Plan.**

**Read this entire Combined Evidence of Coverage and Disclosure Form completely and carefully. It describes the rights and obligations of Members and Plan. It is the Member's responsibility to understand the terms and conditions of this document. Individuals with special dental care needs should read carefully those sections that apply to them.**

The Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the Agreement between the Group and the Plan. The Group Dental Service Agreement must be consulted to determine the exact terms and conditions of coverage. For further information about the benefits to which a Member is entitled, contact Plan or selected Plan Dentist at 800.443.2995.

A copy of the Group Dental Service Agreement will be sent to Group administrator when Plan receives a completed Enrollment Form and payment of the monthly Prepayment Fee. Member may also obtain a copy of Group Dental Service Agreement from Member's Group administrator or from Plan upon request.

**PRIVACY NOTICE**

**A STATEMENT DESCRIBING THE PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF DENTAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.**

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## **ARTICLE I**

### **DEFINITIONS**

- 1.1 **Agreement:** Shall mean the contract between the Plan and Group and as defined in Article II of the Group Dental Service Agreement.
- 1.2 **Copayment:** Shall mean an additional fee charged to Member by Plan Provider, which has been approved by the Director of the Department and identified in the Copayment Schedule.
- 1.3 **Dependent:** Shall mean the spouse or domestic partner (as defined in Section 297 of the California Family Code) of any Subscriber and all newborn infants from and after the moment of birth, natural children, adopted children from the date of placement, stepchildren or the domestic partner's children, foster children and children whom the Subscriber is required to provide coverage pursuant to a court or administrative order. All such children shall be under age twenty-six (26). Dependent shall be eligible for coverage on the day the Subscriber is eligible for coverage or when he or she attains the status of a dependent, whichever is later.
- Dependent shall also mean the child of Subscriber age twenty-six (26) or over who is not capable of self-sustaining employment by reason of a physically or intellectually disabling injury, illness or condition and chiefly dependent on Subscriber for maintenance and support.
- 1.4 **Department:** Shall mean the California Department of Managed Health Care, which is within the California Business, Transportation and Housing Agency that has charge of the execution of California laws relating to health care service plans and health care service plan business, including, but not limited to, those laws directing the department to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interest of members.
- 1.5 **Effective Date:** The date when coverage begins under Agreement.
- 1.6 **Emergency Dental Services:** Shall mean those dental services a layperson reasonably believes are required for alleviation of severe pain, bleeding, swelling, or immediate diagnosis and treatment of unforeseen dental conditions which, if not treated, could reasonably be expected to result in placing a Member's dental health in serious jeopardy even if it is later discovered that a dental emergency did not exist. If Member requires emergency medical care, Member should immediately call 9-1-1 or seek immediate care at the closest hospital or trauma center.
- 1.7 **Exclusion:** Shall mean a dental service or treatment that is not a Plan Benefit.
- 1.8 **Limitation:** Shall mean a dental service or treatment that is restricted by the Plan.
- 1.9 **Member:** Shall mean a Subscriber or Dependent who is enrolled in Plan.
- 1.10 **Group:** Shall mean the employer, association or other organization identified in Agreement.
- 1.11 **Plan Dentist:** Shall mean a California licensed dentist who is under contract with Plan and responsible for providing Plan Benefits to Members of Plan.
- 1.12 **Plan Dentist Directory:** Shall mean the list of Plan Dentists and Plan Specialists with whom the Plan contracts and Members may see to obtain Plan Benefits. Upon request, Plan will forward the Plan Dentist Directory to any Member.

- 1.13 **Plan Provider:** Shall mean a Plan Dentist or Plan Specialist. The term shall include any hygienists and technicians recognized by the dental profession who act with and assist Plan Dentist or Plan Specialist. 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.
- 1.14 **Plan Specialist:** Shall mean a California licensed dentist practicing in a dental specialty under contract with Plan to provide specialty services to Members including endodontics, orthodontics, pedodontics, periodontics and oral surgery.
- 1.15 **Plan Benefits:** Shall mean the dental services and treatment provided to Members under Agreement, subject to any limitations and exclusions.
- 1.16 **Prepayment Fee:** Shall mean the monthly fee paid by Group to Plan for each Member, including administrative or other fees necessary for provision of coverage.
- 1.17 **Service Area:** Shall mean the geographic area designated by the Plan and approved by the Department where Plan is licensed to provide Plan Benefits.
- 1.18 **Subscriber:** Shall mean an employee, member or beneficiary of Group who is eligible to participate in Plan under the eligibility requirements determined by Group.
- 1.19 **Surcharge:** Shall mean an additional fee which is charged to a Subscriber or Member for a Plan Benefit but which is not approved by the Director of the Department, provided for in this Agreement, and disclosed in the Combined Evidence of Coverage and Disclosure Form.
- 1.20 **Urgent Services:** Shall mean immediate dental treatment required to prevent serious deterioration of Member's dental health resulting from unforeseen illness or injury for which treatment cannot be delayed.

## **ARTICLE II**

### **ELIGIBILITY, PREPAYMENT FEES AND EFFECTIVE DATE**

- 2.1 **Plan Year:** The initial Plan Year shall begin on the Effective Date and last for a period of twelve (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.
- 2.2 **Eligibility:** Subscriber and his or her Dependent(s) are eligible to become Members of Plan during the open enrollment period set by Group. For individuals who desire coverage after the Effective Date, eligibility shall be subject to Group's eligibility rules. Each Member must work or live in Plan's Service Area to participate in Plan.

A Dependent shall be eligible for coverage on the day Subscriber is eligible for coverage or when he or she attains the status of a Dependent, whichever is later. All newborn Dependents shall be eligible for coverage from and after the moment of birth. If an additional Prepayment Fee is required for coverage of a newborn Dependent, Group must notify Plan. Any resulting Prepayment Fee must be paid within thirty-one (31) days after the date of birth.

Coverage shall be available to each minor child placed for adoption with the Subscriber or Subscriber's spouse, from and after the date on which the adoptive child's birth parent or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form or a relinquishment form, granting the Subscriber or the Subscriber's spouse the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the Subscriber's or Subscriber's spouse's right to control the health care of the child placed for adoption.

Group will pay monthly Prepayment Fees to Plan and will let Member know the amount that Member must pay. Plan may amend Agreement, including the amount of Prepayment Fees, from time to time, at Plan's discretion. Such an amendment may change the amount of Prepayment Fees Member is required to pay. Plan shall provide Group with written notice of any change in the amount of Prepayment Fee at least thirty (30) days before any change in the Prepayment Fee takes effect.

If Plan fails to pay a Plan Provider, Member is not responsible to Plan Provider for sums owed by Plan. If Plan fails to pay a non-Plan Provider, Member may be liable to non-Plan Provider for costs of services rendered.

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

### **ARTICLE III**

#### **SUBSCRIBER COPAYMENTS AND OTHER CHARGES**

- 3.1 **Copayments:** Member shall be responsible for payment of all Copayments and charges for non-Plan Benefits. Member shall pay dental provider at the time service is rendered. Member may have an option to pay according to provider's billing procedures.
- 3.2 **Other Charges:** If a Member desires to receive dental care or services not listed as a Plan Benefit, the Member is financially obligated to pay the Plan Provider for such dental care or treatment.
- 3.3 **Change in Copayment:** Plan, at Plan's discretion, may change the amount of any required Copayment. Plan shall provide Group with written notice of any change in Copayment amount at least thirty (30) days before any such change takes effect.

### **ARTICLE IV**

#### **DENTAL BENEFITS AND COVERAGES**

- 4.1 **Plan Benefits:** Please refer to the Copayment Schedule, which is attached to this Combined Evidence of Coverage and Disclosure Form, for a complete list of Plan Benefits. Plan shall provide services to Member as set forth in the Combined Evidence of Coverage and Disclosure Form and the Copayment Schedule. Plan Benefits are subject to various limitations and exclusions. Plan Benefits are provided to Members for the term of this Agreement. Plan, at Plan's discretion, may change the Plan Benefits provided. Plan shall provide Group with written notice of any change in Plan Benefits at least thirty (30) days before any such change takes effect

Plan Benefits for services provided through teledentistry shall be the same as if provided in person.

**IMPORTANT:** If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at 800.443.2995 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

- 4.2 **Provision of Plan Benefits/Plan Providers:** Each Member shall select a Plan Dentist from the Plan Dentist Directory furnished by Group to Member. Specialty services covered by Plan may be obtained from a Plan Specialist.

Except in the case of Emergency Dental Services, Urgent Services outside the Service Area or an unavailable Plan Provider, this Agreement provides only for services performed by a Plan Provider. In situations involving Emergency Dental Services, a Member may go to any available dentist. Plan covers Urgent Services by a non-Plan Provider outside the Service Area as a Plan Benefit. If a Member's Plan Provider is unavailable to provide routine dental care within a reasonable timeframe, the Member must contact the Plan and the Plan will refer the Member to a dentist who is available. Plan shall not have any liability due to treatment by hospital, other person, institution, or group unless such treatment was for Emergency Dental Services, such treatment was for Urgent Services outside the Plan's Service Area or such treatment was approved in advance by Plan.

If a new Member was receiving services from a Non-Plan Provider at the time that Member's coverage became effective under this Agreement, the Member may request continuity of care with that Non-Plan Provider.

This Agreement provides for dental care services only. It is not an insurance policy. It does not reimburse Member or Group in cash, except for Emergency Dental Services, Urgent Services when a Member is outside the Service Area or in situations in which a Plan Provider is not available. The Member must seek reimbursement from the Plan if he or she receives Emergency Dental Services, Urgent Services or reimbursable care from a non-Plan Provider.

- 4.3 **Assignment of Benefits:** Member's coverage is intended for the sole use and benefit of Member and cannot be transferred to a third party.
- 4.4 **Current Dental Terminology:** The most current dental terminology may not be reflected in Agreement. However, Plan Benefits will be based on the most current dental terminology. From time to time, and with at least thirty (30) days' written notice to Group, Plan reserves the right to update this EOC to reflect the most current dental terminology.

## **ARTICLE V**

### **CHOICE OF PROVIDERS/FACILITIES**

**PLEASE READ THE FOLLOWING SECTION SO YOU WILL KNOW FROM WHOM OR FROM WHAT GROUP OF PROVIDERS PLAN BENEFITS MAY BE OBTAINED.**

- 5.1 **Selection of Provider:** Information on Plan Providers, including names, addresses, and telephone numbers, are available to the Members through the Plan Dentist Directory. Each Member shall select a Plan Dentist from Plan Dentist Directory. To obtain Plan Benefits, Member shall contact the Plan Dentist selected by Member from the Plan Dentist Directory.
- A. **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 20th of the month will be effective on the 1st of the next following month. Change requests received after the 20th of the month will be effective the 1st of the second following month. If Member requires services from a Plan Dentist other than their selected Plan Dentist after the 20th of the month, Member may contact the Plan. The Plan will work with the Member to make the Member effective immediately with a 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. Plan Specialist: If Member requires specialty services covered under Plan that cannot be provided by Member's selected Plan Dentist, Member may obtain services from a Plan Specialist. The Member simply contacts the Plan Specialist directly to obtain Plan Benefits. No referral from the selected Plan Dentist or Plan is needed. Except in cases involving Emergency Dental Services, Urgent Services outside of Service Area or reimbursable services provided by a non-Plan Provider (see section 4.2 under Article IV), Plan does not cover services received from non-Plan Providers.
- C. Failure to Select a Plan Dentist: The Plan will contact any Member, or his or her representative, who has failed to select a Plan Dentist. The Member will be reminded that it is his or her responsibility to select a Plan Dentists from the Plan Dentist Directory.

If a Plan Provider's contract is terminated while Member is receiving ongoing treatment from that Provider, the member may request the Plan to arrange for treatment to continue with terminated Plan Provider or the Plan will arrange for an available Plan Provider to assume services to ensure that the services being rendered by the terminated Plan Provider are completed.

- 5.2 **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.
- 5.3 **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.
- 5.4 **Plan Provider Facilities**: The operation and maintenance of Plan Provider's facilities and equipment shall be completely under the control of Plan Provider. This includes the selection of staff, supervision of personnel and operation of the professional practice. It also includes rendition of any particular professional service or treatment.
- 5.5 **Plan Provider Compensation**: Plan compensates Plan Providers in a variety of ways. Providers are paid on a "capitated basis." This means Plan pays a per Member per month fee to the Plan Dentist who provides services to Plan's Members. Also, some Plan Providers may be paid on a discounted fee-for-service basis. This means the Plan reimburses the Plan Provider for the care provided in an amount that is less than what he or she typically charges for dental care. Plan's Providers are always required by Plan to provide services in a quality manner in accordance with detailed regulatory and contractual requirements. These requirements help reduce overall costs by providing quality care emphasizing preventive health care access and utilization of effective treatment methods.

## **ARTICLE VI** **LIMITATIONS AND EXCLUSIONS**

### **LIMITATIONS OF BENEFITS**

1. Dentures may be replaced as necessary for the health of the Member as deemed necessary by the Plan Dentist who is providing treatment or evaluation.
2. Orthodontic treatment is limited as follows:
  - a) Limited orthodontic treatment of tooth guidance orthodontia is limited to eighteen (18) consecutive months of continuous treatment.



- b) Active orthodontic treatment (from placement of banding/bracketing) is limited to twentyfour (24) consecutive months of continuous treatment and is allowed once per lifetime.
  - c) Retention treatment is limited to twelve (12) consecutive months. Ongoing retention treatment past twelve (12) consecutive months may be subject to additional fees as determined by Plan Specialist. Additional fees will be the sole responsibility of the Member.
3. Failure of Member to follow a prescribed course of dental treatment may result in the need for additional dental services. Such dental services may result in additional Copayments and charges for non-Plan Benefits.
  4. Copayments listed for fixed prosthetic restorations do not cover the cost of any precious or semiprecious alloy used in their fabrication. This limitation applies to ADA codes 2750, 2752, 2790, 2792, 6210, 6212, 6240, 6242, 6750, 6752, 6790 and 6792. These ADA Codes along with the corresponding Service Descriptions are listed in the Copayment Schedule.

### **EXCLUSIONS OF BENEFITS**

1. Any procedure not specifically listed in the Copayment Schedule is not a Plan Benefit.
2. Any dental service started and completed prior to Effective Date is not covered. Any dental service listed in the Copayment Schedule, started, but not completed prior to the Effective Date, will be considered a Plan Benefit only if completion of the dental service is provided by a Plan Provider unless the Member requests the Plan to arrange for treatment to continue with the Non-Plan Provider. For dental services other than orthodontics, Member will be responsible for the full Copayment amount plus any applicable alloy or precious metals fee for the dental service completed under the Plan. For orthodontic services, Member will be responsible for the full orthodontic Copayment, which will be prorated according to the Plan Provider's plan of treatment and normal billing procedures based on the percentage of orthodontic work completed prior to the Effective Date. Any dental service started after Member's termination is not covered.
3. Treatment for malignancies, neoplasms or cysts, including biopsy, is not covered.
4. Implants, surgery for the insertion of implants, all related implant appliances and restorations, removable or fixed, are not covered.
5. 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.
6. Extractions for non-symptomatic third molars (wisdom teeth) are not covered. This exclusion also applies to extractions for non-symptomatic third molars after the completion of orthodontic treatment. Examples of symptomatic conditions include decay, odontogenic cysts, chronic pericoronitis and infection.
7. Complete oral rehabilitation or reconstruction involving replacement of six (6) or more missing teeth using fixed prosthetic restorations and/or appliances is not covered.
8. Restorations and splints used to increase vertical dimension, restore occlusion, or replace/stabilize tooth structure loss by attrition are not covered.
9. Replacement of dentures, appliances or bridgework due to loss or theft is not covered.

10. Except for Emergency Dental or Urgent Services outside the Service Area or in situations in which a Plan Provider is not available, services provided by non-Plan dentists are not covered unless preauthorized by Plan.

## **ARTICLE VII**

### **EMERGENCY DENTAL SERVICES**

- 7.1 **Emergency Dental Services:** Emergency Dental Services are those dental services a layperson reasonably believes are required for alleviation of severe pain, bleeding, swelling, or immediate diagnosis and treatment of unforeseen dental conditions which, if not treated, could reasonably be expected to result in placing a Member's dental health in serious jeopardy even if it is later discovered that a dental emergency did not exist. If Member requires emergency medical care, Member should immediately contact 9-1-1 or go to the nearest trauma center or hospital. Plan shall arrange for Emergency Dental Services twenty four (24) hours a day, seven (7) days a week. A Member may go to any available dentist for treatment of Emergency Dental Services. The Plan includes, as a Plan Benefit, Urgent Services by a non-Plan Provider outside the Service Area. The Member must seek reimbursement from the Plan if he or she receives Emergency Dental Services or Urgent Services outside of the Service Area.
- A. **Inside Plan Service Area:** If Member is in the Service Area and needs Emergency Dental Services, Member must first contact his or her selected Plan Dentist to arrange for Emergency Dental Services. If Member's Plan Dentist is unavailable, Member may obtain Emergency Dental Services from any licensed dentist. Plan will reimburse Member for the actual cost of Emergency Dental Services only, subject to a deduction for any Copayments, limitations and exclusions.
- B. **Outside Plan Service Area:** If Member is not in the Service Area and needs Emergency Dental Services or Urgent Services, Member should seek treatment from any licensed dentist. Plan will reimburse Member for the actual cost of Emergency Dental Services or Urgent Services, subject to a deduction for any Copayments, limitations and exclusions.
- C. **Additional Conditions:** Reimbursement for Emergency Dental Services provided by non-Plan Dentists is subject to the following additional conditions:
1. Plan Benefits include care required for alleviation of severe pain, bleeding, swelling, such that a prudent layperson may believe that urgent or unscheduled dental care is required, even if it is later discovered that an emergency did not in fact exist.
  2. The Member must notify Plan or Plan Dentist of his or her condition and the service arrangements within forty-eight (48) hours, or such other reasonable time, given the Member's condition, after provision of Emergency Dental Services. The Member must also return to Plan Dentist for continued services if indicated.
  3. Reimbursement requests must be in writing and received by Plan within one (1) year 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 of charges to the Plan within one (1) year from the date Plan Benefits were provided shall not nullify or reduce reimbursement so long as it was not reasonably possible for Member to provide the information and the information is provided as soon as reasonably possible.
  5. If Emergency Dental Services are performed at a hospital or outpatient care facility rather than a dentist's office, Plan shall pay only applicable dental charges. Plan shall

not pay for covered Emergency Dental Services if Plan determines that such Emergency Dental Services were never performed.

## **ARTICLE VIII**

### **REIMBURSEMENT PROVISIONS**

- 8.1 **Reimbursement Provisions:** Member seeking reimbursement from the Plan shall furnish Plan with written proof that Member paid the provider for Plan Benefits. Member requests for reimbursement must be in writing. Such requests must include invoices (or other similar documentation) describing services provided, the name and address of the dentist providing such dental services, and the date such services were performed. If Plan reimburses Member, the Plan may seek recovery of any payment made by Plan for which it is entitled to reimbursement.
- A. **Proof of Charges:** If Member is charged for Plan Benefit, written proof of charges must be furnished to Plan. This must be within sixty (60) days after receipt of benefit.
  - B. **Failure to Furnish Proof of Charges:** Failure to furnish proof to Plan within the required time shall not nullify or reduce reimbursement so long as it was not reasonably possible for Member to provide the information and the information is provided as soon as reasonably possible.
  - C. **Reimbursement of Charges:** Reimbursement requests will be processed within thirty (30) working days of receipt of the claim. If additional information is needed in order to process a claim, Plan will contact Member within thirty (30) working days of receipt of the claim to request the missing information. Upon receipt of the missing information, Plan will reimburse or deny the claim within thirty (30) working days. If a claim is denied in part or in full, a written notice containing the reason for the denial shall be provided to the Member.
  - D. **Review:** Member may obtain a review of the denial through Plan's Member Appeals Process (Article X).

## **ARTICLE IX**

### **COORDINATION OF BENEFITS**

- 9.1 **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 managed care plan, the plan that covers the individual as Subscriber of Group is primary.
2. If Member has coverage under both a managed care plan and an indemnity plan, the managed care 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.
4. If two or more plans cover a person as a dependent child of separated or divorced parents, the plan of the parent with custody of the child is primary. Then, the plan of the spouse of the parent with custody, and finally, the plan of the parent not having custody.

The above may not apply in the case of a divorce decree, court action or the like, 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 Member's 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 Member's 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 X**

### **MEMBER APPEALS PROCESS**

- 10.1 **Resolution Procedures:** Member shall contact Plan or Plan Provider regarding any inquiries, complaints or grievances. In addition to contacting the Plan, Members should forward any question or concern directly to Plan Provider rendering service to resolve the issue immediately. Plan inquiries or dissatisfactions may be sent to Plan by telephone, through the Plan's website or in writing.

**Definition:** A "complaint" or "grievance" is defined as a written or oral expression of dissatisfaction regarding the Plan and/or Plan Provider, including quality of care concerns, cancellation, rescission or nonrenewal and shall include a complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative. In cases where the Plan is unable to distinguish between a "grievance" and an "inquiry," it shall be considered a grievance.

A. **Complaints:**

Member may contact Plan customer service department regarding any inquiry. The complaint or grievance must be reported within one hundred eighty (180) calendar days. A Plan representative will assess and resolve Member's concern. If Member is not satisfied with the resolution, Member may file a verbal or written complaint.

**Plan will acknowledge the verbal complaint within five (5) business days by notifying the complainant in writing. Plan will investigate the complaint and will provide a written resolution to Member within thirty (30) days. A complaint form is also available on our web site, [www.udcdentalcalifornia.com](http://www.udcdentalcalifornia.com).**

- B. **Appeal Procedure:** If Member is not satisfied with the resolution of a complaint, Member may request an appeal of Plan's assessment. Upon receipt of an appeal request, Plan will provide Member with Plan's appeal process as defined by Plan or in accordance with applicable state law.

- C. Complaints Regarding Emergency Dental Services: Notwithstanding any provision in the Agreement to the contrary, investigation and resolution of complaints regarding presently occurring Emergency Dental Services shall be concluded in accordance with the immediacy of the case and shall not exceed twenty-four (24) hours from receipt of Member's complaint.
- D. Expedited Grievances: Notwithstanding any provision to the contrary for issues involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function; or cancellation, rescission, or nonrenewal; the Plan will investigate and provide a written resolution within three (3) days from receipt of the grievance. The Member may also file a complaint involving an Expedited Grievance immediately with the California Department of Managed Health Care. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Website <http://www.dmhca.ca.gov> has complaint forms, IMR application forms and instructions online.

You may also file a complaint with the California Department of Managed Health Care. California law sets forth this right in the following statement:

The California Department of Managed Health Care is responsible for regulating health care services plans. If you have a grievance against your health plan, you should first telephone the health plan at **800.443.2995** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1.877.688.9891**) for the hearing and speech impaired. The department's Internet Website <http://www.dmhca.ca.gov> has complaint forms, IMR application forms and instructions online.

## **ARTICLE XI**

### **TERMINATION OF BENEFITS**

- 11.1 **Termination of Eligibility:** If Subscriber is terminated or leaves Group, Subscriber and his or her Dependents shall continue to be covered until Plan is notified in writing of Subscriber's termination.
- 11.2 **Member Termination:** Member coverage shall terminate as follows:
  - A. On the last day of the month for which Group has placed Member on eligibility list and has paid the proper Prepayment Fee.
  - B. If Member ceases to meet the eligibility requirements of Group, coverage will terminate on the next Prepayment Fee due date.
  - C. If Member commits fraud or intentional misrepresentation of material fact under the terms of the Plan Agreement, coverage for Member will terminate upon thirty (30) days' written notice. This will not be enforced after Member's enrollment has been in effect for two (2) years from the Effective Date of Agreement.

- D. 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.
- E. Coverage for Subscriber's Dependents will be terminated if the coverage for Subscriber terminates for any reason. This is subject to continuation privileges for certain Dependents as set forth herein.
- F. 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 a Subscriber is and continues to be incapable of self-sustaining employment by reason of a disability or physical handicap. Such a Dependent must be chiefly dependent on the Subscriber for maintenance and support, and the Subscriber must furnish proof of incapacity and dependency to Plan within thirty-one(31) days of the child attaining limiting age. The proof of incapacity and dependency must be furnished every year thereafter, if requested by Plan.

A Member who believes his or his dependent's enrollment has been cancelled or not renewed because of health status may submit a complaint or grievance to the Plan and request a review of cancellation by the Department of Managed Health Care. The Department of Managed Health Care's telephone number is (888-466-2219).

## **ARTICLE XII**

### **CONTINUATION OF COVERAGE/COBRA/CAL-COBRA**

- 12.1 **Continuation of Coverage Under the Plan:** If this Agreement is terminated, each Plan Provider shall complete all dental services started prior to the date of termination. This is pursuant to the terms of an agreement between Plan and Plan Provider and as required by state law. Should a Member in orthodontia treatment terminate for any reason, each Plan Provider shall complete all orthodontia services started prior to the effective date of termination so long as the Member 1) continues to pay any required Copayments and 2) continues to receive care from the same Plan Provider who planned and initiated orthodontia treatment for the Member. If Member discontinues treatment by missing scheduled appointments or fails to abide by the Plan Provider's prescribed treatment plan, the Plan will terminate the continuation of coverage for the Member's orthodontic care.
- 12.2 **Continuation of Coverage Under Federal COBRA:** This section applies only if Group is an employer required to offer Federal COBRA. Under the provisions of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99-272 (COBRA), Member is granted the right to continue coverage beyond the date Member's coverage would otherwise terminate. Coverage under the Agreement shall continue until terminated by the applicable provisions of Federal law. Member should contact Group concerning eligibility.
- 12.3 **Continuation of Coverage Under Cal-COBRA:** This section applies only if Group is an employer required to offer Cal-COBRA. Under the provisions of California Health and Safety Code, Section 1366.20, Members who are Qualified Beneficiaries may qualify for coverage under the California Continuation Benefit Replacement Act (Cal-COBRA). Cal-COBRA also extends the continuation coverage period for eligible COBRA beneficiaries to 36 months.

**Cal-COBRA Definitions:** *Qualified Beneficiary*—a Member covered under the Plan on the day before a *Qualifying Event* including the spouse or dependent child(ren) of a Subscriber, or a child born to or placed for adoption with a Subscriber during the Cal-COBRA continuation period and who is enrolled in the Plan as a dependent within 30 days of the child's birth or placement for adoption. *Qualifying Event*—any of the following events, which would result in a loss of coverage under the Plan: 1) Termination of employment of Subscriber (for any reason other than gross

misconduct) or reduction in hours of employment of Subscriber below the minimum required for coverage; 2) The death of the Subscriber; 3) Divorce or legal separation of the Subscriber and his or her spouse; 4) the Subscriber's entitlement to Medicare; or 5) the loss of dependent child status.

**Notice Under Cal-COBRA:** If a Qualified Beneficiary loses coverage under the Plan due to the Subscriber's termination of employment or reduction in hours, the Group is required to send all Qualified Beneficiaries a notice of the right to continue coverage under Cal-COBRA. If a Qualified Beneficiary loses coverage under the Plan due to a Qualifying Event other than the Subscriber's termination of employment or reduction in hours (as mentioned above), Qualified Beneficiary must inform the Plan or Group within 60 days of the Qualifying Event. If the Plan or Group is not notified within 60 days, no continuation of coverage will be provided. Upon the Plan's receipt of timely notification of the Qualifying Event, the Plan or Group will send Qualified Beneficiary an official written notice ("Initial Notice") of the Cal-COBRA continuation rights, including eligibility requirements and the prepayment fees that those selecting continuation of coverage must pay.

**Election of Continuation of Coverage Under Cal-COBRA:** If a Qualified Beneficiary chooses to continue coverage under Cal-COBRA, Group must be notified in writing within the later of: (1) 60 days of the date the Qualified Beneficiary receives notice of continuation rights or (2) 60 days of the date coverage under the Plan ends because of the Qualifying Event. Failure to notify the Group within the later of 60 days of receiving the Initial Notice or 60 days of the date coverage under the Plan ends because of the Qualifying Event will disqualify the Qualified Beneficiary from receiving continuation coverage. The request for continuation coverage must be made in writing and delivered by first-class mail or other reliable means of delivery.

**Termination of Coverage Under Cal-COBRA:** Coverage under Cal-COBRA ends on the earliest of: (1) 36 months after the Qualifying Event, if the Qualifying Event was a termination of Subscriber's employment or a reduction of work hours, death of the Subscriber, a divorce or legal separation from the Subscriber, or the end of dependent child status; (2) 36 months from the date the Subscriber became entitled to Medicare, if the Qualifying Event was the Subscriber's entitlement to Medicare; (3) The date a Qualified Beneficiary becomes covered under federal COBRA; (4) The end of the period for which required monthly prepayment fees were last paid; (5) The date a Qualified Beneficiary becomes covered under any other plan, unless the other plan contains an exclusion or limitation relating to a pre-existing condition of the Qualified Beneficiary; (6) The date a Qualified Beneficiary becomes entitled to Medicare; or (7) The date the Group's participation in the Plan terminates. (Note: If the Agreement between the Plan and Group is terminated before the date coverage would ordinarily end, Qualified Beneficiaries may elect continuation coverage from the new group plan with which Subscriber's employer contracts, if employer contracts with a new group plan.)

**Prepayment Fee:** A Qualified Beneficiary who elects Cal-COBRA coverage is responsible for paying the entire prepayment fee. This prepayment fee shall be no more than 110% percent of the regular applicable prepayment fee. These prepayment fees may be adjusted in the future if the applicable regular prepayment fee changes. There is a 45-day grace period for the payment of the *first* prepayment fee. Accordingly, the Qualified Beneficiary's first prepayment fee must be mailed to UDC Dental California, Inc. no later than 45 days after Qualified Beneficiary gives written notice to UDC Dental California, Inc. or the Group that Qualified Beneficiary is electing continuation coverage under Cal-COBRA. The first prepayment fee must equal all prepayment fees then due. There is a grace period of 30 days for the subsequent *regularly scheduled* monthly prepayment fees. **This is the maximum grace period allowed, as the Plan does not provide for an extension of the grace period beyond what is required by law. If Qualified Beneficiary's prepayment fee is not mailed to Plan by the end of the 30-day grace period, Qualified Beneficiary's coverage with Plan will be terminated and Qualified Beneficiary will not have an opportunity to reinstate coverage.**

## **ARTICLE XIII**

### **RENEWAL PROVISION**

- 13.1 **Renewal:** After the initial Plan Year, each Plan Year of Agreement shall have a twelve-month term. It shall be automatically renewed at the Anniversary Date unless otherwise terminated. Plan has the right to change the Prepayment Fees or any other provisions of the Agreement. Plan shall not increase the Prepayment Fees or reduce Plan Benefits unless notice of such increase or reduction is provided in writing to Group at least thirty (30) days prior to the Agreement renewal Effective Date.

## **ARTICLE XIV**

### **REQUIRED NOTICES**

- 14.1 **Public Policy Participation:** As required by California law, subscribers and/or enrollees may participate with the establishment of public policy through membership on the plan's Board of Directors. Such subscribers and/or enrollees shall be persons who are not employees of the plan, providers of health care services, subcontractors to the plan or group contract brokers, or persons financially interested in the plan. In connection with the selection of enrollee and subscriber members, the plan shall generally consider the makeup of its subscriber and enrollee population, including, but not limited to, factors such as ethnic extraction, demography, occupation, and geography, as well as identifiable and individual group participation. Such selection of subscriber and/or enrollee members shall be conducted on a fair and reasonable basis. For further information on public policy participation contact the plan at [slfgriev@sunlife.com](mailto:slfgriev@sunlife.com) or by calling (800)-443-2995.

- 14.2 **Second Opinions:** A second opinion may be required for Members in situations where diagnosis is indefinable by the Plan Dentist or if additional consultation is required to determine an appropriate course of dental treatment for Member.

If Plan Dentist or Member desires a second opinion to determine recommended dental treatment, Member shall contact Plan. Plan will coordinate with selected Plan Dentist to submit records and/or xrays, if appropriate, to Plan for review by Plan dental director. The dental director may provide a timely second opinion to Plan Dentist or Member. The dental director may personally evaluate Member if further evaluation is required or may refer Member to another Plan Dentist, Plan Specialist or an appropriately qualified health care professional. An appropriately qualified health care professional is a licensed health care provider who is acting within his or her scope of practice and has a clinical background with training and expertise relating to the particular condition associated with the request of a second opinion. Any additional exams or consultations will not be charged to Member. Second opinions that have not been approved by the Plan are not a Plan Benefit.

- 14.3 **Organ and Tissue Donation and Procedures:** Advancements in organ transplant technology allow more patients to benefit from organ transplants, but the supply of organs has not kept pace with the number of patients eligible for transplantation. The number of organs transplanted from deceased individuals increased from 10,964 in 1988 to 16,802 in 1996. But there are more than 54,000 individuals remaining on the waiting list. Organ donation is not limited by age. While two-thirds of the donors were between ages 18 through 49 in 1988, by 1996 only half were in this age group. The proportion of donors aged 50 and older doubled from about 12 percent in 1988 to about 26 percent in 1996. Each deceased donor contributes an average of three organs. Organ donation begins at the hospital when a patient is identified as a potential organ donor. Only those patients pronounced brain dead are considered for organ donation, though some organs are recovered from donors declared dead by traditional cardiac death criteria. Once a potential organ donor has been identified, a staff member of the hospital or the organ procurement organization



will contact the individual's family, which has the opportunity to donate organs. If the family consents, the organ procurement organization coordinates the organ procurement activities, including preserving the organs and arranging for the transportation of the organs to the hospital where the transplant will be performed. For more information or a free donor card, you may call the Organ and Tissue Acquisition Center at 619.292.8750.

14.4 **Timely Access to Care:** Members have the right to timely access to care and telephone assistance, including the right to appointments and care within the following timeframes:

- Emergency care is available 24 hours a day, 7 days per week.
- Urgent care is available within 72 hours, depending on individual dental needs and as required by professionally recognized standards of dental practice.
- Providers must have an answering machine or answering service during non-business hours which provide instructions concerning how to obtain emergency care or urgent care, including how to contact another provider who has agreed to be on-call to screen by phone or deliver emergency care or urgent care.
- Non-urgent appointments are available within 36 business days of the request for an appointment.
- Preventative dental care appointments are available within 40 business days of the request for an appointment.
- The Plan will ensure that, during normal business hours, a Customer Service Representative will answer the phone within 10 minutes.
- If it is necessary for the Member or provider to reschedule an appointment, the appointment must be promptly rescheduled in a manner that is appropriate for the Member's health care needs: within 24 hours for emergency care, within 72 hours for urgent care, within 36 business days for initial/routine care, and within 40 business days for preventative care.
- If the Member needs an interpreter, interpretation services are available upon request. A request for interpretation services at the time of the Member's appointment will not delay the scheduling of the Member's appointment. The Plan and provider will coordinate the interpretation services with the scheduled appointment.
- Provider facilities should meet Americans with Disabilities Act (ADA) access guidelines including wheel-chair accessibility.

If the Member has questions about appointment wait times or if the Member would like to request an interpreter, please contact our [Client Service Department] at 800-443-2995.

## **ARTICLE XV** **GENERAL PROVISIONS**

15.1 **Amendments:** By mutual consent, Plan and Group may modify, amend or alter Agreement.

Except as otherwise agreed, 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 applicable law.

15.2 **Distribution of Plan Materials and Notices to Members:** Plan may be obligated under state law to give certain notices or Plan materials to Member. If so, it shall be sufficient for Plan to give notice or Plan materials to the Group's delegate, unless state law requires otherwise. Group shall then be responsible for providing notice or Plan materials to Subscribers.

15.3 **Circumstances Beyond Plan's Control:** In the event that the rendition of dental services hereunder is delayed or rendered impractical due to circumstances not reasonably within the control of Plan, including, but not limited to complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes or disability of a significant number of Providers, neither Plan nor any Provider shall have any liability or obligation to provide services on account of such delay.

- 15.4 **Major Disaster or Epidemic:** In the event of any major disaster or epidemic, Provider shall render dental services insofar as practical according to his or her best judgement, within the limitations of such facilities and personnel as are then available. Neither Plan nor Provider shall have any liability or obligation for delay or failure to provide dental services due to lack of available facilities or personnel if it occurred as a result of such disaster or epidemic.

**TO CONTACT CUSTOMER SERVICE, CALL 800.443.2995**

## Notice

**Timely Access to Care:** Members have the right to timely access to care and telephone assistance, including the right to appointments and care within the following timeframes:

- Emergency care is available 24 hours a day, 7 days per week.
- Urgent care is available within 72 hours depending on individual dental needs and as required by professionally recognized standards of dental practice.
- Providers must have an answering machine or answering service during non-business hours which provide instructions concerning how to obtain emergency or urgent care, including how to contact another provider who has agreed to be on-call to screen by phone or deliver emergency or urgent care.
- Non-urgent appointments are available within 36 business days of the request for an appointment.
- Preventative dental care appointments are available within 40 business days of the request for an appointment.
- The Plan will ensure that, during normal business hours, a Customer Service Representative will answer the phone within 10 minutes.
- If it is necessary for the Member or provider to reschedule an appointment, the appointment must be promptly rescheduled in a manner that is appropriate for the Member's health care needs: within 24 hours for emergency care, within 72 hours for urgent care, within 36 business days for initial/routine care, and within 40 business days for preventative care.
- If the Member needs an interpreter, interpretation services are available upon request. A request for interpretation services at the time of the Member's appointment will not delay the scheduling of the Member's appointment. The Plan and provider will coordinate the interpretation services with the scheduled appointment.
- Provider facilities should meet Americans with Disabilities Act (ADA) access guidelines including wheel-chair accessibility.

If appropriate care from a Plan Provider is not accessible, the Plan will refer the Member to an appropriate Non-Plan Provider. Cost-sharing will be equal to the cost-sharing the Member would have paid for similar service from a Plan Provider.

If the Member has questions about appointment wait times or if the Member would like to request an interpreter, please contact our Client Service Department at 800-443-2995.

## Notice

**Confidentiality of Medical Information:** Members have the right to request that protected health information ("PHI") is communicated directly to Member in an alternative manner or at an alternative location. PHI is information that may identify Member as an individual and relates to Member's past, present, or future physical or mental health or condition. It also includes information related to the past, present, or future payment for Member's health care.

To request that the Plan communicate about PHI in an alternative manner or at an alternative location send a written request to:

**UDC Dental California, Inc.  
Attention: HIPAA Privacy Officer  
621 Capitol Mall, Suite 900  
Sacramento, CA 95814**

The request must specify what parts of Member's PHI the request covers. It must also specify how and where the Member should be contacted. For example, Member may request that the Plan only contact Member at their work address or via Member's work e-mail.

For further questions about the information described in the notice, write to the above address or call 800-247-6875.

**OUR HIPAA NOTICE OF PRIVACY PRACTICES CONTAINS ADDITIONAL INFORMATION DESCRIBING OUR PRIVACY PRACTICES, A PAPER COPY OF WHICH WILL BE FURNISHED UPON REQUEST.**

UDC Dental California, Inc.  
621 Capitol Mall, Suite 900  
Sacramento, CA 95814

(800-443-2995)

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**DHMO DENTAL SERIES 89 PLAN COPAYMENT SCHEDULE**

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This Plan provides only for services performed by a Plan Dentist or a Plan Specialist, except in the case of (i) Emergency Dental Services, (ii) Urgent Services outside the Service Area, (iii) an unavailable Plan Dentist or an unavailable Plan Specialist, and (iv) reimbursable services by a non-Plan Dentist or a non-Plan Specialist, (see section 4.2 under Article IV in the Combined Evidence of Coverage and Disclosure Form). In situations involving Emergency Dental Services, a Member may go to any available dentist. Plan covers Urgent Services by a non-Plan Dentist or a non-Plan Specialist outside the Service Area as a Plan Benefit.

The dental services covered under the Plan and the copayment amount for those services may be different for Plan Dentists versus Plan Specialists. Not all dental services listed in **Section 1. PLAN DENTIST SERVICES** are included in **Section 2. PLAN SPECIALIST SERVICES**. Not all dental services listed in **Section 2. PLAN SPECIALIST SERVICES** are included in **Section 1. PLAN DENTIST SERVICES**. If a Member sees a Plan Dentist for services not listed in **Section 1. PLAN DENTIST SERVICES**, the dental services will not be covered under the Plan and the Plan Dentist may charge the Member the usual and customary rate for those services. If a Member sees a Plan Specialist for services not listed in **Section 2. PLAN SPECIALIST SERVICES**, the dental services will not be covered under the Plan and the Plan Specialist may charge the Member the usual and customary rate for those services.

**1. PLAN DENTIST SERVICES**

The dental services listed in the following schedule are covered only when provided by the Member's selected Plan Dentist. The Member will be responsible for paying the amount listed in the "Member Copayment" column at the time the service is received, or in accordance with the selected Plan Dentist's billing procedures. To fully understand the benefits, exclusions and limitations of this plan, the Member should consult the Combined Evidence of Coverage and Disclosure Form.

Services marked with a single asterisk (\*) below may also require separate payment by the Member for the entire cost of any precious or semi-precious alloy used in their fabrication. The additional precious or semi-precious alloy charges must be paid to the Plan Dentist in addition to any applicable copayment for the service. Services marked with a quadruple asterisk (\*\*\*\*) below are subject to a separate Copayment for restorations and endodontic posts and cores placed after root canal therapy.

Payment for each service of a Non-Plan Dentist (at that dentist's normal retail charge) is the responsibility of the Member, except for limited Plan Benefits for covered dental Emergency Services for temporary pain relief.

ADA Code**	Service Description**	Member Copayment
	<b>Appointments</b>	
D0120	Periodic oral evaluation - established patient.....	No Charge
D0140	Limited oral evaluation - problem focused.....	No Charge
D0150	Comprehensive oral evaluation - new or established patient.....	No Charge
D0180	Comprehensive periodontal evaluation - new or established patient.....	No Charge

<b>Appointments</b>	
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician..... No Charge
D9440	Office visit - after regularly scheduled hours..... 20.00
<b>Diagnostic Dentistry</b>	
D0210	Intraoral - comprehensive series of radiographic images..... No Charge
D0220	Intraoral-periapical first radiographic image..... No Charge
D0230	Intraoral-periapical each additional radiographic image..... No Charge
D0240	Intraoral-occlusal radiographic image..... No Charge
D0250	Extraoral-2D projection radiographic image created using a stationary radiation source, and detector..... No Charge
D0260	Extraoral-each additional radiographic image..... No Charge
D0270	Bitewing-single radiographic image..... No Charge
D0272	Bitewing-two radiographic images..... No Charge
D0273	Bitewings-three radiographic images..... No Charge
D0274	Bitewing-four radiographic images..... No Charge
D0330	Panoramic radiographic image..... No Charge
D0415	Collection of microorganisms for culture and sensitivity..... No Charge
D0425	Caries susceptibility tests..... No Charge
D0460	Pulp vitality tests..... No Charge
D0470	Diagnostic casts..... No Charge
None	Periodontal probing in the presence of periodontal disease*** ..... 10.00
<b>Preventive Dentistry</b>	
D1110	Prophylaxis - adult (once in every 6 months)..... No Charge
D1120	Prophylaxis - child (once in every 6 months)..... No Charge
D1206	Topical application of fluoride varnish..... No Charge
D1310	Nutritional counseling for control of dental disease..... No Charge
D1330	Oral hygiene instructions..... No Charge
D1351	Sealant - per tooth..... 10.00
D1510	Space maintainer - fixed - unilateral..... 70.00
D1516	Space maintainer - fixed - bilateral, maxillary..... 70.00
D1517	Space maintainer - fixed - bilateral, mandibular..... 70.00
D1520	Space maintainer - removable - unilateral..... 80.00
D1526	Space maintainer - removable - bilateral, maxillary..... 80.00
D1527	Space maintainer - removable - bilateral, mandibular..... 80.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary..... No Charge
D1552	Re-cement or re-bond bilateral space maintainer - mandibular..... No Charge
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant..... No Charge
None	Additional prophylaxis*** ..... 25.00
<b>Restorative Dentistry</b>	
D2140	Amalgam - one surface, primary or permanent**** ..... No Charge
D2150	Amalgam - two surfaces, primary or permanent**** ..... No Charge
D2160	Amalgam - three surfaces, primary or permanent**** ..... No Charge
D2161	Amalgam - four or more surfaces, primary or permanent**** ..... No Charge
D2330	Resin-based composite - one surface, anterior**** ..... No Charge
D2331	Resin-based composite - two surfaces, anterior**** ..... No Charge
D2332	Resin-based composite - three surfaces, anterior**** ..... No Charge
D2391	Resin-based composite - one surface, posterior..... 25.00
D2392	Resin-based composite - two surfaces, posterior..... 35.00
D2393	Resin-based composite - three surfaces, posterior..... 45.00
D2740	Crown - porcelain/ceramic..... 89.00
D2750	Crown - porcelain fused to high noble metal..... 89.00
D2751	Crown - porcelain fused to predominantly base metal..... 89.00
D2752	Crown - porcelain fused to noble metal..... 89.00
D2790	Crown - full cast high noble metal..... 85.00
D2791	Crown - full cast predominantly base metal..... 85.00
D2792	Crown - full cast noble metal..... 85.00
D2799	Interim crown - further treatment or completion of diagnosis necessary prior to final impression..... 95.00
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration..... 5.00

<b>Restorative Dentistry</b>	
D2920	Re-cement or re-bond crown..... 10.00
D2930	Prefabricated stainless steel crown - primary tooth..... 35.00
D2931	Prefabricated stainless steel crown - permanent tooth..... 70.00
D2940	Protective restoration..... No Charge
D2950	Core buildup, including any pins..... 25.00
D2951	Pin retention - per tooth, in addition to restoration..... 5.00
D2952	Cast post and core in addition to crown****..... 35.00
D2954	Prefabricated post and core in addition to crown****..... 50.00
D2960	Labial veneer (resin laminate) - chairside..... 100.00
D2962	Labial veneer (porcelain laminate) - laboratory..... 190.00
D2980	Crown repair necessitated by restorative material failure..... 25.00
None	Temporary filling***..... No Charge
<b>Endodontics</b>	
D3110	Pulp cap - direct (excluding final restoration)..... No Charge
D3120	Pulp cap - indirect (excluding final restoration)..... No Charge
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament..... 10.00
D3310	Endodontic therapy, anterior tooth (excluding final restoration)..... 95.00
D3320	Endodontic therapy, premolar tooth (excluding final restoration)..... 130.00
D3330	Endodontic therapy, molar (excluding final restoration)..... 165.00
D3346	Retreatment of previous root canal therapy - anterior..... 95.00
D3347	Retreatment of previous root canal therapy - premolar..... 130.00
D3348	Retreatment of previous root canal therapy - molar..... 165.00
D3410	Apicoectomy - anterior..... 125.00
D3421	Apicoectomy - premolar (first root)..... 160.00
D3425	Apicoectomy - molar (first root)..... 180.00
D3426	Apicoectomy - each additional root..... 75.00
D3430	Retrograde filling - per root..... 50.00
D3450	Root amputation - per root..... 75.00
D3920	Hemisection (including any root removal), not including root canal therapy..... 100.00
<b>Periodontics</b>	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant..... 100.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant..... 60.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant..... 250.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant..... 155.00
D4322	Splint - intra-coronal; natural teeth or prosthetic crowns..... 60.00
D4323	Splint - extra-coronal; natural teeth or prosthetic crowns..... 50.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant..... 40.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant..... 25.00
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit..... 35.00
D4910	Periodontal maintenance..... 25.00
None	Periodontal hygiene instructions***..... No Charge
<b>Removable Prosthodontics (Removable Dentures)</b>	
D5110	Complete denture - maxillary..... 125.00
D5120	Complete denture - mandibular..... 125.00
D5130	Immediate denture - maxillary..... 140.00
D5140	Immediate denture - mandibular..... 140.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)..... 135.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)..... 135.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)..... 150.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)..... 150.00

<b>Removable Prosthodontics (Removable Dentures)</b>		
D5410	Adjust complete denture - maxillary.....	10.00
D5411	Adjust complete denture - mandibular.....	10.00
D5421	Adjust partial denture - maxillary.....	10.00
D5422	Adjust partial denture - mandibular.....	10.00
D5511	Repair broken complete denture base, mandibular.....	30.00
D5512	Repair broken complete denture base, maxillary.....	30.00
D5611	Repair resin partial denture base, mandibular.....	30.00
D5612	Repair resin partial denture base, maxillary.....	30.00
D5621	Repair cast partial framework, mandibular.....	30.00
D5622	Repair cast partial framework, maxillary.....	30.00
D5630	Repair or replace broken clasp - per tooth.....	30.00
D5640	Replace broken teeth - per tooth.....	30.00
D5650	Add tooth to existing partial denture.....	30.00
D5730	Reline complete maxillary denture (chairside).....	40.00
D5731	Reline complete mandibular denture (chairside).....	40.00
D5740	Reline maxillary partial denture (chairside).....	40.00
D5741	Reline mandibular partial denture (chairside).....	40.00
D5750	Reline complete maxillary denture (laboratory).....	65.00
D5751	Reline complete mandibular denture (laboratory).....	65.00
D5760	Reline maxillary partial denture (laboratory).....	65.00
D5761	Reline mandibular partial denture (laboratory).....	65.00
D5850	Tissue conditioning, maxillary.....	10.00
D5851	Tissue conditioning, mandibular.....	10.00
<b>Fixed Prosthodontics (Bridges or Fixed Partial Dentures)</b>		
D6210	Pontic - cast high noble metal'.....	85.00
D6211	Pontic - cast predominantly base metal.....	85.00
D6212	Pontic - cast noble metal'.....	85.00
D6240	Pontic - porcelain fused to high noble metal'.....	89.00
D6241	Pontic - porcelain fused to predominantly base metal.....	89.00
D6242	Pontic - porcelain fused to noble metal'.....	89.00
D6721	Retainer crown - resin with predominantly base metal.....	70.00
D6750	Retainer crown - porcelain fused to high noble metal'.....	89.00
D6751	Retainer crown - porcelain fused to predominantly base metal.....	89.00
D6752	Retainer crown - porcelain fused to noble metal'.....	89.00
D6790	Retainer crown - full cast high noble metal'.....	85.00
D6791	Retainer crown - full cast predominantly base metal.....	85.00
D6792	Retainer crown - full cast noble metal'.....	85.00
D6930	Re-cement or re-bond fixed partial denture.....	10.00
D6940	Stress breaker.....	90.00
D6980	Fixed partial denture repair, by report.....	40.00
<b>Oral Surgery</b>		
D7111	Extraction, coronal remnants - primary tooth.....	17.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).....	17.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.....	30.00
D7220	Removal of impacted tooth - soft tissue.....	60.00
D7230	Removal of impacted tooth - partially bony.....	70.00
D7240	Removal of impacted tooth - completely bony.....	100.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.....	120.00
D7250	Removal of residual tooth roots (cutting procedure).....	30.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.....	100.00
D7280	Exposure of an erupted tooth.....	150.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.....	35.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.....	70.00
D7471	Removal of lateral exostosis (maxilla or mandible).....	95.00
D7510	Incision and drainage of abscess - intraoral soft tissue.....	30.00
D7961	Buccal/labial frenectomy (frenulectomy).....	70.00
D7962	Lingual frenectomy (frenulectomy).....	70.00



<b>Anesthesia, Analgesia, and Sedation</b>	
D9215	Local anesthesia..... No Charge
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide..... 15.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes..... 120.00
D9944	Occlusal guard - hard appliance, full arch..... 100.00
D9945	Occlusal guard - soft appliance, full arch..... 100.00
D9946	Occlusal guard - hard appliance, partial arch..... 100.00
D9972	External bleaching-per arch-performed in office..... 175.00
None	External bleaching, both arches""..... 300.00
<b>Orthodontics</b>	
None	Diagnostic workup with radiographs/model""..... 175.00
D8030	Limited orthodontic treatment of the adolescent dentition..... 900.00
D8040	Limited orthodontic treatment of the adult dentition..... 1000.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition..... 1695.00
D8090	Comprehensive orthodontic treatment of the adult dentition..... 1895.00
D8660	Pre-orthodontic treatment examination to monitor growth and development..... 35.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))..... 95.00
None	Adjusting retainer, by report""..... No Charge
None	Elastics, by report""..... No Charge
None	Final orthodontics records, by report""..... 125.00
None	Reattached brackets and bands (limit 3 times)""..... 7.00
None	Replace broken ligature wires (limit 3 times)""..... 5.00
None	Premium transparent brackets, per arch""..... 200.00

## 2. PLAN SPECIALIST SERVICES

Should the Member require dental services that his or her selected Plan Dentist is unable to provide, he or she may obtain those services from a Plan Specialist. No referral is needed from the selected Plan Dentist in order for the Member to obtain services from a Plan Specialist. To fully understand the benefits, exclusions and limitations of this plan, the Member should consult the Combined Evidence of Coverage and Disclosure Form.

There is an applicable copayment amount for a Plan Specialist's service. The Member is responsible for paying the entire copayment amount at the time the service is received, or in accordance with the Plan Specialist's billing procedures.

Payment for each service of a Non-Plan Specialist (at that specialist's normal retail charge) is the responsibility of the Member, except for limited Plan Benefits for covered dental Emergency Services for temporary pain relief.

ADA Code**	Service Description**	Member Copayment
<b>Appointments</b>		
D0140	Limited oral evaluation - problem focused.....	No Charge
D0150	Comprehensive oral evaluation - new or established patient.....	No Charge
D0180	Comprehensive periodontal evaluation - new or established patient.....	No Charge
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.....	No Charge
<b>Diagnostic Dentistry</b>		
D0210	Intraoral - comprehensive series of radiographic images.....	25.00
D0220	Intraoral-periapical first radiographic image.....	No Charge
D0230	Intraoral-periapical each additional radiographic image.....	No Charge
D0240	Intraoral-occlusal radiographic image.....	No Charge
D0250	Extraoral-2D projection radiographic image created using a stationary radiation source, and detector.....	No Charge
D0260	Extraoral-each additional radiographic image.....	No Charge
D0330	Panoramic radiographic image.....	25.00

ADA Code**	Service Description**	Member Copayment
D0415	Collection of microorganisms for culture and sensitivity.....	No Charge
D0425	Caries susceptibility tests.....	No Charge
D0460	Pulp vitality tests.....	No Charge
D0470	Diagnostic casts.....	No Charge
None	Periodontal probing in the presence of periodontal disease***.....	10.00
<b>Preventive Dentistry</b>		
D1110	Prophylaxis - adult (once in every 6 months).....	No Charge
D1120	Prophylaxis - child (once in every 6 months).....	No Charge
D1206	Topical application of fluoride varnish.....	No Charge
D1351	Sealant - per tooth.....	10.00
D1510	Space maintainer - fixed - unilateral.....	70.00
D1516	Space maintainer - fixed - bilateral, maxillary.....	70.00
D1517	Space maintainer - fixed - bilateral, mandibular.....	70.00
D1520	Space maintainer - removable - unilateral.....	80.00
D1526	Space maintainer - removable - bilateral, maxillary.....	80.00
D1527	Space maintainer - removable - bilateral, mandibular.....	80.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary.....	No Charge
D1552	Re-cement or re-bond bilateral space maintainer - mandibular.....	No Charge
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant.....	No Charge
None	Additional prophylaxis***.....	25.00
<b>Restorative Dentistry</b>		
D2140	Amalgam - one surface, primary or permanent****.....	No Charge
D2150	Amalgam - two surfaces, primary or permanent****.....	No Charge
D2160	Amalgam - three surfaces, primary or permanent****.....	No Charge
D2161	Amalgam - four or more surfaces, primary or permanent****.....	No Charge
D2330	Resin-based composite - one surface, anterior****.....	No Charge
D2331	Resin-based composite - two surfaces, anterior****.....	No Charge
D2332	Resin-based composite - three surfaces, anterior****.....	No Charge
D2930	Prefabricated stainless steel crown - primary tooth.....	35.00
D2931	Prefabricated stainless steel crown - permanent tooth.....	70.00
D2940	Protective restoration.....	No Charge
<b>Endodontics</b>		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.....	10.00
D3310	Endodontic therapy, anterior tooth (excluding final restoration).....	95.00
D3320	Endodontic therapy, premolar tooth (excluding final restoration).....	130.00
D3330	Endodontic therapy, molar (excluding final restoration).....	165.00
D3346	Retreatment of previous root canal therapy - anterior.....	95.00
D3347	Retreatment of previous root canal therapy - premolar.....	130.00
D3348	Retreatment of previous root canal therapy - molar.....	165.00
D3410	Apicoectomy - anterior.....	125.00
D3421	Apicoectomy - premolar (first root).....	160.00
D3425	Apicoectomy - molar (first root).....	180.00
D3426	Apicoectomy - each additional root.....	75.00
D3430	Retrograde filling - per root.....	50.00
D3450	Root amputation - per root.....	75.00
D3920	Hemisection (including any root removal), not including root canal therapy.....	100.00
<b>Periodontics</b>		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.....	100.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.....	60.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.....	250.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.....	155.00

ADA Code**	Service Description**	Member Copayment
D4322	Splint - intra-coronal; natural teeth or prosthetic crowns.....	60.00
D4323	Splint - extra-coronal; natural teeth or prosthetic crowns.....	50.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.....	40.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant.....	25.00
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.....	35.00
D4910	Periodontal maintenance.....	25.00
None	Periodontal hygiene instructions***.....	No Charge
<b>Removable Prosthodontics (Removable Dentures)</b>		
D5850	Tissue conditioning, maxillary.....	10.00
D5851	Tissue conditioning, mandibular.....	10.00
<b>Fixed Prosthodontics (Bridges or Fixed Partial Dentures)</b>		
<b>Oral Surgery</b>		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.....	30.00
D7220	Removal of impacted tooth - soft tissue.....	60.00
D7230	Removal of impacted tooth - partially bony.....	70.00
D7240	Removal of impacted tooth - completely bony.....	100.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.....	120.00
D7250	Removal of residual tooth roots (cutting procedure).....	30.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.....	100.00
D7280	Exposure of an erupted tooth.....	150.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.....	35.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.....	70.00
D7471	Removal of lateral exostosis (maxilla or mandible).....	95.00
D7510	Incision and drainage of abscess - intraoral soft tissue.....	30.00
D7961	Buccal/labial frenectomy (frenulectomy).....	70.00
D7962	Lingual frenectomy (frenulectomy).....	70.00
<b>Anesthesia, Analgesia, and Sedation</b>		
D9215	Local anesthesia.....	No Charge
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide.....	15.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.....	120.00
<b>Orthodontics</b>		
None	Diagnostic workup with radiographs/model***.....	175.00
D8030	Limited orthodontic treatment of the adolescent dentition.....	900.00
D8040	Limited orthodontic treatment of the adult dentition.....	1000.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition.....	1695.00
D8090	Comprehensive orthodontic treatment of the adult dentition.....	1895.00
D8660	Pre-orthodontic treatment examination to monitor growth and development.....	35.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)).....	95.00
None	Adjusting retainer, by report***.....	No Charge
None	Elastics, by report***.....	No Charge
None	Final orthodontics records, by report***.....	125.00
None	Reattached brackets and bands (limit 3 times)***.....	7.00
None	Replace broken ligature wires (limit 3 times)***.....	5.00
None	Premium transparent brackets, per arch***.....	200.00

\*\*Current Dental Terminology © 2022 American Dental Association. All rights reserved.

\*\*\*Sevice does not have an American Dental Association Current Dental Terminology code or descriptor.

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to ask about written information in (your language), first call your plan's phone number at **1.800.443.2995**. Someone who speaks (your language) can help you. If you need more help, call the HMO Help Center at **1.888.466.2219**.

IMPORTANTE: Puede obtener la ayuda de un interprete sin costo alguno para hablar con su médico o con su plan de salud. Para obtener la ayuda de un interprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su plan de salud al **1.800.443.2995**. Alguien que habla español puede ayudarlo. Si necesita ayuda adicional, llame al Centro de ayuda de HMO al **1.888.466.2219**.



## HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice describes your rights and our responsibilities concerning your protected health information ("PHI").

PHI is information that may identify you as an individual and relates to your past, present, or future physical or mental health or condition. It also includes information related to the past, present, or future payment for your health care.

This Notice applies only to Sun Life's\* dental, vision, expense-based cancer, long-term care, and other "health plans" pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Health plans are individual or group products that provide, or pay the cost of, medical care. This Notice does not apply to our life insurance, disability insurance, or other products that are not health plans.

### **Your Privacy is Important to Sun Life**

We are committed to maintaining the privacy and security of your PHI as required by law. We must provide you with a copy of this Notice and abide by the terms of this Notice. We reserve the right to change the terms of this Notice. If we do make changes, the new provisions will apply to all PHI that we maintain. If we make a material change to our Notice, we will mail you a revised Notice.

### **Primary Uses and Disclosures of Your PHI**

The following describes how we are most likely to use and/or disclose your PHI. If state law further restricts how we can use and disclose information, we will follow applicable state laws.

### ***Treatment, Payment or Health Care Operations***

#### Treatment

We are not a health care provider. However, we can use or disclose your PHI for treatment purposes. For example, we may disclose your PHI if your doctor requests it for treatment purposes.

#### Payment

We may use or disclose your PHI to obtain premiums or provide coverage and benefits under your health plan. For example, we may disclose information about your eligibility for our health plan coverage when a provider requests it. Another example includes the use of your information to determine if a treatment that you received was medically necessary.

#### Health Care Operations

We may use or disclose your PHI to run our business and contact you as necessary.

For example, we may use or disclose your PHI for underwriting, conducting audits, or for medical reviews of claims.

#### ***Business Associates***

We may disclose your PHI to our business associates to perform various functions on our behalf. Examples of such functions include claims administration or enrollment. We require business associates to agree in writing to contract terms designed to safeguard your information.

#### ***Plan Sponsor***

We may disclose your PHI to the plan sponsor of your group health plan.

### **Other Possible Uses and Disclosures**

The following describes other possible ways in which we may use or disclose your PHI.

#### ***Required by Law***

We will use or disclose your PHI when required to do so by federal, state, or local law.

#### ***Public Health Activities***

We may use or disclose PHI for public health activities as permitted or required by law. Examples include preventing or controlling public health risks or reporting child abuse or neglect to an appropriate government authority.

#### ***Abuse or Neglect***

We may disclose PHI about you if we believe you are a victim of abuse, neglect, or

domestic violence. We will do so if in our judgment it is necessary to prevent serious harm to you or others.

#### ***Health Oversight Activities***

We may disclose your PHI to a health oversight agency for activities authorized by law. This might include audits, investigations, and other activities necessary for appropriate oversight.

#### ***Legal Proceedings***

We may use or disclose your PHI in the course of a judicial or administrative proceeding. This might occur if a court orders us to do so or in response to some other lawful process.

#### ***Law Enforcement***

We may disclose your PHI to law enforcement officials as required by law or for certain other reasons. An example includes providing evidence of a crime that occurred on our premises.

#### ***Decedents***

We may disclose PHI to a coroner, medical examiner, or funeral director so they can perform their legal duties.

#### ***Donation/Transplantation***

We may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

#### ***Research***

We may disclose your PHI for research purposes, subject to certain conditions to protect your privacy.

#### ***To Prevent a Serious Threat to Health or Safety***

We may use or disclose your PHI if we believe it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

#### ***Specialized Government Functions***

We may disclose your PHI for certain specialized government functions, such as military, national security, and presidential protective services.

#### ***Workers' Compensation***

We may use or disclose your PHI to comply with workers' compensation laws and other similar programs.

#### ***Others Involved in Your Health Care***

We may disclose your PHI to a family member or other individual that you identify. We will do so if the information is directly relevant to that person's involvement with your health care or payment of your health care. We also may disclose your PHI to a public or private entity assisting in a disaster relief effort. If you are not present or able to agree, then we will use our professional judgment to determine whether the disclosure is in your best interest.

### ***Genetic Information***

We may not use or disclose any genetic information for underwriting purposes for all health plans. This prohibition does not apply to long term care.

## **Other Uses and Disclosures Made Only With Your Written Authorization**

We will not use or disclose your PHI except as described above unless we have your written authorization. If we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. If we contact you for our fundraising, we will provide you a right to opt out of such communications. Also, most uses and disclosures of PHI for marketing purposes, and sales of PHI, require your authorization. If you provide us with such an authorization, you may revoke the authorization in writing at any time. Your revocation will be effective for future uses and disclosures of PHI.

However, the revocation will not be effective to the extent we already acted in reliance on your authorization.

## **Your Rights**

The following information describes your rights with respect to your PHI.

### ***Right to Request a Restriction***

You have the right to request restrictions on the PHI we use or disclose about you. Your request must tell us: (1) what information you wish to limit; and (2) how you want to limit our use and/or disclosure.

*We are not required to agree to your request.* If we do agree, we will follow the restriction unless the information is needed to provide you emergency treatment.

### ***Right to Request Confidential Communications***

You may request that we communicate with you about PHI in an alternative manner or at an alternative location. You must clearly state that a disclosure of all or part of your PHI may endanger you. Your request must specify what parts of your PHI that your requests covers. It must also specify how and where you wish to be contacted. For example, you can ask that we only contact you at your work address or via your work e-mail.

### ***Right to Inspect and Copy***

You have the right to inspect and copy your PHI. This includes medical, billing, payment, enrollment, claims and other records used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes and certain other information.

Your request may include an electronic copy in certain cases if you make this request in writing.

If you request a copy of your PHI, we may charge a reasonable, cost-based fee.

We may deny your request to inspect and copy your PHI in certain limited cases. If we deny you access to your PHI, you may request a review of the denial. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same person who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

### ***Right to Amend***

If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. Your written request should include the reason the amendment is necessary.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the PHI is maintained by another entity, and not by us. If we deny your request, you have the right to file a statement of disagreement with us. We will link your statement of disagreement with the disputed information. All future disclosures of the

disputed information will include your statement.

***Right of an Accounting***

You have a right to an accounting of most disclosures of your PHI, with certain exceptions. These exceptions include disclosures made for treatment, payment, health care operations, and certain other disclosures. An accounting will list the date(s) of the disclosure, to whom we made the disclosure, a brief description of the PHI disclosed, and the purpose for the disclosure.

Your request may be for disclosures made up to 6 years before the date of your request. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost

involved. We will also provide you with an opportunity to withdraw or modify your request before you incur any costs.

***Right to a Paper Copy of This Notice***

You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically.

***Breach Notification***

We will notify you if there is a breach of your unsecured health information as required by law or where we otherwise deem appropriate.

***Complaints***

If you believe that we have violated your privacy rights, you may file a complaint with us. All complaints must be in writing. You may also submit a complaint to the Secretary of the U.S. Department of Health and Human Services.

We will not penalize or in any other way retaliate against you for filing a complaint.

**How to Exercise Your Rights or Request More Information**

To fulfill any of the above requests, send your written request to:

*SLF US Compliance  
Department  
Sun Life Financial  
One Sun Life Executive Park  
Wellesley Hills, MA 02481  
Attention: HIPAA Privacy  
Officer.*

For further questions about the information described in the Notice, you may write to the above address or call 1-800-247-6875.

\*In this notice, "Sun Life," "we," "us," and "our" refer to Sun Life Assurance Company of Canada, Sun Life and Health Insurance Company (U.S.), Professional Insurance Company, and the following prepaid dental companies: DentiCare of Alabama, Inc., Union Security DentalCare of Georgia, Inc., Union Security DentalCare of New Jersey, Inc., UDC Dental California, Inc., UDC Ohio, Inc., United Dental Care of Arizona, Inc., United Dental Care of Colorado, Inc., United Dental Care of Michigan, Inc., United Dental Care of Missouri, Inc., United Dental Care of New Mexico, Inc., United Dental Care of Texas, Inc., United Dental Care of Utah, Inc.

Effective date of this notice: October 1, 2019