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800.821.1294**

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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 800.821.1294.

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 nineteen (19), unmarried and chiefly dependent on a Subscriber for support. 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.

Eligibility may be extended up to age twenty- eight (28) for unmarried children who are chiefly dependent on Subscriber for maintenance and support and are registered students in regular, full- time attendance at an accredited school, college or university. Dependent shall also mean the child of Subscriber age nineteen (19) or over not capable of self- sustaining employment by reason of a disability or physical handicap and chiefly dependent on Subscriber for maintenance and support.

1.4 **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 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 from a 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 collectively 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 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 until Member returns to the Service Area.

**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 12 consecutive calendar months. Each subsequent Plan Year shall begin on the Anniversary Date and last for a period of twelve (12) consecutive calendar months. The Anniversary Date for this plan is January 1.
- 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 or domestic partner, 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 or domestic partner 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 or domestic partner'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 applicable Copayment to Plan Provider at the time service is rendered. Member may have an option to pay according to provider's billing procedures. Member should meet with Plan Provider prior to obtaining dental care if the Member is unable to pay the Copayment once treatment is completed.
- 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 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.
- 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 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 for reimbursement 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.

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 Evidence of Coverage and Disclosure Form 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 20<sup>th</sup> of the month will be effective on the 1<sup>st</sup> of the next following month. Change requests received after the 20<sup>th</sup> of the month will be effective the 1<sup>st</sup> of the second following month. 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, Plan will arrange for treatment to continue with terminated Plan Provider or 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. Plan or Plan Provider shall have the right to refuse treatment to any Member who: (1) fails to follow a prescribed course of treatment; (2) fails to keep confirmed appointments; (3) fails or refuses to pay Copayments or charges for non- covered procedures; (4) uses the relationship for illegal purposes; or (5) otherwise makes the professional relationship unduly burdensome.
- 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 twenty- four (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 semi- precious alloy used in their fabrication. This limitation applies to ADA codes 2750, 2752, 2790, 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. For dental services other than orthodontics, Member will be responsible for the full Copayment amount 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 pre- authorized 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 or domestic partner 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 or in writing.

Definition: A "complaint" or "grievance" is defined by the Plan as well as under California law as a written or oral expression of dissatisfaction regarding the Plan and/or Plan Provider, including quality of care concerns, 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. Verbal Complaints:

Member may contact Plan customer service department regarding any inquiry, complaint or grievance that cannot be resolved to Member's satisfaction. This occurs after speaking directly with the dentist or other concerned party. A Plan customer service representative will assess and resolve Member's concern. If Member is not satisfied with the resolution, Member may file a written complaint to Plan. Plan customer service representative will provide Member with the guidelines. In addition, such representative will provide complaint form to be completed. **A complaint form is also available on our web site, [www.udcdentalcalifornia.com](http://www.udcdentalcalifornia.com).**

B. Written Complaints:

Member may complete a complaint form or other similar correspondence describing his or her dissatisfaction with service or care delivered by Plan or Plan Dentist. Plan will acknowledge the written 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 (30) calendar days. In matters of quality of care or clinical issues, an appropriate health professional will be consulted.

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

- D. 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.

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 800.821.1294 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.HMO.2219) and a TDD line (1.877.688.9891) for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.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 material misrepresentation in the use of services or facilities, coverage for Member will terminate immediately upon written notice to Group.
  - D. If Member commits fraud or material misrepresentation on the Enrollment Form, coverage will terminate immediately upon written notice to Group. This provision will not be enforced after two (2) years from the time Member's coverage begins.
  - E. If Group or Plan terminates Agreement, coverage for Member shall cease on the termination date. This shall be subject to any notice to Group required by state law.
  - F. If Member fails to make required payments, including Copayments, Plan reserves the right to terminate coverage upon sixty (60) days' written notice to Group. Prepayment Fees received for terminated Member for the period after termination date shall be refunded to Group. Thereafter, Plan shall have no further liability or responsibility to Member.

- G. A Member, after reasonable efforts, may be unable to establish and maintain a satisfactory dentist- patient relationship with Plan Provider. If so, Plan reserves the right to terminate coverage upon sixty (60) days' written notice to Group. Prepayment Fees received for terminated Member for the period after termination date shall be refunded to Group. Thereafter, Plan shall have no further liability or responsibility to Member.
- H. Coverage for 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.
- I. Once a Member is no longer qualified as a Dependent, coverage for that Member will terminate. Coverage shall not terminate while a Dependent child of 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 the limiting age. The proof of incapacity and dependency must be furnished to Plan every year thereafter, if requested by Plan.
- J. If Member no longer works or lives in Service Area.

A Member who believes his or his dependent's enrollment has been canceled or not renewed because of health status may request a review of cancellation by the Department of Managed Health Care. The Department of Managed Health Care's telephone number is **800.HMO.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, domestic partner 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 (8) 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:** Plan seeks applicants who would be interested in participating in a committee (the Public Policy Committee) for the purposes of establishing the public policy of Plan. The committee consists of three Plan members, Plan's dental director and Plan's administrator. Members shall serve a one- year term while Plan's administrator and dental director will be permanent Members. Plan will reimburse Members \$50 per meeting for their participation.

The Public Policy Committee meets quarterly to review Plan's performance and future direction of Plan operations. Information regarding Plan operations, grievance log reports, financial operations and the like will be made available to Members for review and comment. Recommendations and reports from the Public Policy Committee will be furnished to the Plan's board of directors at the next regularly scheduled board meeting. Receipt of the recommendations and any reports from the Public Policy Committee shall be considered by the Plan's board of directors and duly noted in the board's minutes.

Membership in the Public Policy Committee is voluntary, will be determined by the entire Public Policy Committee with special consideration being made to the ethnicity, geographic location and economic status of Member applicants. If Member is interested in a Public Policy Committee membership, please call Plan at 800.443.2995 for information about the next meeting and how Plan chooses committee Members. Plan's board of directors has established a committee to advise us on public policy. It meets at least once every quarter and includes Members. A Member may attend committee meetings.

- 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 x-rays, 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.

## 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 California 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 California 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**



**UDC Dental California, Inc.  
3333 Camino del Rio South  
Suite 300  
San Diego, CA 92108  
800.821.1294**

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**PLUS COPAYMENT SCHEDULE**

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Benefits provided by: UDC Dental California, Inc.  
3333 Camino del Rio South  
Suite 300  
San Diego, CA 92108  
800.821.1294

**1. PLAN DENTIST SERVICES (subject to limitations and exclusions listed in the Combined Evidence of Coverage and Disclosure Form):**

This Copayment Schedule provides a complete list of dental services covered under the Plan. These dental services are covered only when provided by Member's selected Plan Dentist. Dental services that do not appear on this list are not covered by this Plan. 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 selected Plan Dentist's billing procedures. To fully understand the benefits, exclusions and limitations of this plan, Member should consult the Combined Evidence of Coverage and Disclosure Form to determine specific dental coverage.

**Except in the case of (i) covered dental Emergency Services, (ii) Urgent Services outside of Service Area and (iii) reimbursable services by a non- Plan Dentist (See section 4.2 under Article IV in the Combined Evidence of Coverage and Disclosure Form), payment for all services received from a non- Plan Dentist will be the responsibility of the Member.**

ADA Code**	Service Description**	Member Copayment
<b>Appointments</b>		
None	Routine Office Visit*** .....	5.00
D0120	Periodic oral evaluation.....	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
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment).....	No Charge
D9440	Office visit - after regularly scheduled hours.....	20.00
<b>Diagnostic Dentistry</b>		
D0210	Intraoral - complete series (including bitewings).....	No Charge
D0220	Intraoral - periapical first film.....	No Charge
D0230	Intraoral - periapical each additional film.....	No Charge
D0240	Intraoral - occlusal film.....	No Charge
D0250	Extraoral - first film.....	No Charge
D0260	Extraoral - each additional film.....	No Charge

ADA Code**	Service Description**	Member Copayment
D0270	Bitewing - single film .....	No Charge
D0272	Bitewings - two films .....	No Charge
D0274	Bitewings - four films.....	No Charge
D0330	Panoramic film .....	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 every 6 months).....	No Charge
D1120	Prophylaxis - child (once every 6 months).....	No Charge
D1203	Topical application of fluoride (prophylaxis not included) - child.....	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
D1515	Space maintainer - fixed - bilateral.....	70.00
D1520	Space maintainer - removable - unilateral.....	80.00
D1525	Space maintainer - removable - bilateral.....	80.00
D1550	Re- cementation of space maintainer .....	No Charge
<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.....	45.00
D2392	Resin- based composite - two surfaces, posterior .....	55.00
D2393	Resin- based composite - three surfaces, posterior.....	65.00
D2740	Crown - porcelain/ceramic substrate.....	185.00
D2750	Crown - porcelain fused to high noble metal*.....	195.00
D2751	Crown - porcelain fused to predominantly base metal.....	195.00
D2752	Crown - porcelain fused to noble metal* .....	195.00
D2790	Crown - full cast high noble metal*.....	95.00
D2791	Crown - full cast predominantly base metal .....	95.00
D2792	Crown - full cast noble metal.....	95.00
D2910	Recement inlay, onlay, or partial coverage restoration.....	5.00
D2920	Recement crown.....	5.00
D2930	Prefabricated stainless steel crown - primary tooth.....	25.00
D2940	Sedative filling.....	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

ADA Code**	Service Description**	Member Copayment
D2960	Labial veneer (resin laminate) - chairside.....	100.00
D2980	Crown repair, by report.....	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	Anterior (excluding final restoration).....	95.00
D3320	Bicuspid (excluding final restoration).....	130.00
D3330	Molar (excluding final restoration).....	165.00
D3346	Retreatment of previous root canal therapy - anterior.....	95.00
D3347	Retreatment of previous root canal therapy - bicuspid.....	130.00
D3348	Retreatment of previous root canal therapy - molar.....	165.00
D3410	Apicoectomy/periradicular surgery - anterior.....	125.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).....	160.00
D3425	Apicoectomy/periradicular surgery - molar (first root).....	180.00
D3426	Apicoectomy/periradicular surgery - (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 bounded teeth spaces per quadrant.....	100.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant.....	60.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant.....	250.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant.....	155.00
D4320	Provisional splinting - intracoronal.....	60.00
D4321	Provisional splinting - extracoronal.....	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 comprehensive evaluation and diagnosis.....	35.00
D4910	Periodontal maintenance.....	25.00
None	Periodontal hygiene instructions***.....	No Charge
<b>Prosthodontics, removable</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

ADA Code**	Service Description**	Member Copayment
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).....	150.00
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
D5510	Repair broken complete denture base.....	30.00
D5610	Repair resin denture base.....	30.00
D5620	Repair cast framework.....	30.00
D5630	Repair or replace broken clasp.....	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>Prosthodontics, fixed</b>		
D6210	Pontic - cast high noble metal*.....	115.00
D6211	Pontic - cast predominantly base metal.....	115.00
D6212	Pontic - cast noble metal*.....	115.00
D6240	Pontic - porcelain fused to high noble metal*.....	210.00
D6241	Pontic - porcelain fused to predominantly base metal.....	210.00
D6242	Pontic - porcelain fused to noble metal*.....	210.00
D6721	Crown - resin with predominantly base metal.....	90.00
D6750	Crown - porcelain fused to high noble metal*.....	210.00
D6751	Crown - porcelain fused to predominantly base metal.....	210.00
D6752	Crown - porcelain fused to noble metal*.....	210.00
D6790	Crown - full cast high noble metal*.....	115.00
D6791	Crown - full cast predominantly base metal.....	115.00
D6792	Crown - full cast noble metal*.....	115.00
D6930	Recement 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 - deciduous tooth.....	17.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).....	17.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.....	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

ADA Code**	Service Description**	Member Copayment
D7250	Surgical removal of residual tooth roots (cutting procedure).....	30.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.....	100.00
D7280	Surgical access of an unerupted tooth.....	150.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant.....	35.00
D7320	Alveoloplasty not in conjunction with extractions - 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
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.....	70.00
<b>Other Services</b>		
D9215	Local anesthesia.....	No Charge
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide.....	15.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.....	120.00
D9940	Occlusal guard, by report.....	100.00
D9972	External bleaching - per arch.....	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 visit.....	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 (limited 3 times)***.....	7.00
None	Replace broken ligature wires (limit 3 times)***.....	5.00
None	Premium Transparent brackets, per arch***.....	200.00

The above are covered orthodontic services when provided by a Plan Dentist or a Plan Specialist. Services not specifically included within the above definitions are not covered by the Plan.

- I. **Limited Orthodontic Treatment of Primary, Transitional (mixed primary and permanent), Adolescent, or Adult Dentition.** This is treatment that does not involve all the existing teeth in both upper and/or lower arches. This limited treatment is a one- time treatment in an arch to correct crowding, close an open space between teeth, or upright a malposed tooth. Limited orthodontic treatment for primary, transitional, adolescent and adult teeth is limited to 18 consecutive months of continuous treatment.
  
- II. **Orthodontic Treatment of Adolescent/Adult Dentition.** This is treatment that consists of diagnosis by oral exam, radiographs and study casts (models of teeth/arches) followed by banding and /or bracketing of teeth for active treatment and correction of class I and class II jaw relationships. Comprehensive treatment is followed by a 12- month retention treatment or stage involving construction, placement of retainers and follow- up exams of retained teeth. The comprehensive phase of treatment is limited to 24 consecutive months of continuous treatment. Members are eligible for this treatment once per lifetime. Retention treatment is limited to 12 consecutive months.

**2. PLAN SPECIALIST SERVICES (subject to limitations and exclusions listed in the Combined Evidence of Coverage and Disclosure Form):**

Should member require dental services that the selected Plan Dentist is unable to provide, he may obtain those services from a Plan Specialist. No referral is needed for services from a Plan Specialist. The following Copayment schedule applies to covered services when they are provided by a Plan Specialist. Dental services that do not appear on this list are not covered by this Plan. If the member receives a service listed on the schedule he will be responsible for paying the amount in the "Member Copayment" column at the time the service is received, or in accordance with the Plan Specialist's billing procedures.

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 practitioner providing treatment).....	No Charge
<b>Diagnostic Dentistry</b>		
D0210	Intraoral - complete series (including bitewings).....	25.00
D0220	Intraoral - periapical first film.....	No Charge
D0230	Intraoral - periapical each additional film.....	No Charge
D0240	Intraoral - occlusal film.....	No Charge
D0250	Extraoral - first film.....	No Charge
D0260	Extraoral - each additional film.....	No Charge
D0330	Panoramic film.....	25.00
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 every 6 months).....	No Charge
D1120	Prophylaxis - child (once every 6 months).....	No Charge
D1203	Topical application of fluoride (prophylaxis not included) - child.....	No Charge
D1351	Sealant - per tooth.....	10.00
D1510	Space maintainer - fixed - unilateral.....	70.00
D1515	Space maintainer - fixed - bilateral.....	70.00
D1520	Space maintainer - removable - unilateral.....	80.00
D1525	Space maintainer - removable - bilateral.....	80.00
D1550	Re- cementation of space maintainer.....	No Charge
<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

ADA Code**	Service Description**	Member Copayment
D2930	Prefabricated stainless steel crown - primary tooth.....	25.00
D2940	Sedative filling.....	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	Anterior (excluding final restoration).....	95.00
D3320	Bicuspid (excluding final restoration).....	130.00
D3330	Molar (excluding final restoration).....	165.00
D3346	Retreatment of previous root canal therapy - anterior.....	95.00
D3347	Retreatment of previous root canal therapy - bicuspid.....	130.00
D3348	Retreatment of previous root canal therapy - molar.....	165.00
D3410	Apicoectomy/periradicular surgery - anterior.....	125.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).....	160.00
D3425	Apicoectomy/periradicular surgery - molar (first root).....	180.00
D3426	Apicoectomy/periradicular surgery - (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 bounded teeth spaces per quadrant.....	100.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant.....	60.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant.....	250.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant.....	155.00
D4320	Provisional splinting - intracoronal.....	60.00
D4321	Provisional splinting - extracoronal.....	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 comprehensive evaluation and diagnosis.....	35.00
D4910	Periodontal maintenance.....	25.00
None	Periodontal hygiene instructions***.....	No Charge
<b>Prostodontics, removable</b>		
D5850	Tissue conditioning, maxillary.....	10.00
D5851	Tissue conditioning, mandibular.....	10.00
<b>Oral Surgery</b>		
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.....	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	Surgical removal of residual tooth roots (cutting procedure).....	30.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.....	100.00
D7280	Surgical access of an unerupted tooth.....	150.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant.....	35.00

ADA Code**	Service Description**	Member Copayment
D7320	Alveoloplasty not in conjunction with extractions - 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
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.....	70.00
<b>Other Services</b>		
D9215	Local anesthesia .....	No Charge
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide .....	15.00
D9241	Intravenous conscious sedation/analgesia - first 30 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 visit .....	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 (limited 3 times)*** .....	7.00
None	Replace broken ligature wires (limit 3 times)*** .....	5.00
None	Premium Transparent brackets, per arch*** .....	200.00

The above are covered orthodontic services when provided by a Plan Dentist or a Plan Specialist. Services not specifically included within the above definitions are not covered by the Plan.

- I. **Limited Orthodontic Treatment of Primary, Transitional (mixed primary and permanent), Adolescent, or Adult Dentition.** This is treatment that does not involve all the existing teeth in both upper and/or lower arches. This limited treatment is a one- time treatment in an arch to correct crowding, close an open space between teeth, or upright a malposed tooth. Limited orthodontic treatment for primary, transitional, adolescent and adult teeth is limited to 18 consecutive months of continuous treatment.
- II. **Orthodontic Treatment of Adolescent/Adult Dentition.** This is treatment that consists of diagnosis by oral exam, radiographs and study casts (models of teeth/arches) followed by banding and /or bracketing of teeth for active treatment and correction of class I and class II jaw relationships. Comprehensive treatment is followed by a 12- month retention treatment or stage involving construction, placement of retainers and follow- up exams of retained teeth. The comprehensive phase of treatment is limited to 24 consecutive months of continuous treatment. Members are eligible for this treatment once per lifetime. Retention treatment is limited to 12 consecutive months.

\*Service may also require separate payment for the cost of any precious or semi- precious alloy used in their fabrication.

\*\*Current Dental Terminology © American Dental Association.

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

\*\*\*\*Restorations and endodontic posts and cores placed after root canal therapy are subject to a separate Copayment.

## **HIPAA Notice of Privacy Practices**

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

### **I. Our Commitment**

Union Security Insurance Company and its affiliated prepaid dental companies\* are committed to protecting the personal information entrusted to us by our customers. The trust you place in us when you share your personal information is a responsibility we take very seriously and is the cornerstone of how we conduct our business.

We use the brand name "Assurant Employee Benefits" to associate our products and services and to connect us with the brand of our parent company, Assurant, Inc.

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

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

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

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

- Underwriting our risk and determining rates and premiums for your dental or vision plan;
- Determining your eligibility for benefits;
- Reviewing the competence and qualifications of dental care or other providers;
- Conducting or arranging for dental review, legal services, and auditing functions, including fraud and abuse detection and compliance;
- Business planning and development;
- Business management and general administrative duties such as cost- management, customer service, and resolution of internal grievances;
- Other administrative purposes.

We can also make disclosures under the following circumstances without your permission:

- As required by law, including response to court and administrative orders, or to report information about suspected criminal activity;
- To report abuse, neglect, or domestic violence;
- To authorities that monitor our compliance with these privacy requirements;
- To coroners, medical examiners, and funeral directors;
- For research and public health activities, such as disease and vital statistic reporting;
- To avert a serious threat to health or safety;
- To the military, certain federal officials for national security activities, and to correctional institutions;
- To the entity sponsoring your group dental or vision plan but only for purposes of enrollment, disenrollment, eligibility, or for the purpose of giving the plan sponsor summary information when necessary to help make decisions regarding changes to the plan. If the plan sponsor has certified that its plan documents have been amended to include certain privacy provisions, we may also disclose protected health information to the plan sponsor to carry out plan administration functions that the plan sponsor performs on behalf of the plan;
- To a spouse, family member, or other personal representative if they can show they are assisting in your care or payment of your care and then, without an authorization, only basic information about the status or payment of a claim.

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

### **III. Your Individual Rights**

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

- **To Restrict our Use or Disclosure.** You have the right to ask us to limit our use or disclosure of your PHI. While we will consider your request, we are not legally required to agree to the additional restrictions. If we do agree to all or part of your request, we will inform you in writing. We cannot agree to limit any use and disclosure of your PHI if the use or disclosure is required by law.
- **To Access your PHI.** You have the right to view and/or copy your PHI at any time by contacting us. If you want copies of your PHI, or want your PHI in a special format, we may charge you a fee. You have a right to choose what portions of your PHI you want copied and to have prior notice of copying costs. If for some reason we deny your request for access to your PHI, we will provide a written explanation of why your request was denied and explain how you can appeal the denial.

- **To Amend your PHI.** You have the right to amend your PHI, if you believe it is incomplete or inaccurate. Your request must be in writing, with an explanation of why you feel the information should be amended. If we approve your request to amend your PHI, we will make reasonable efforts to inform others, including people you name, about the amendment to your PHI. We may deny your request for various reasons, for example, if we determine that the information is correct and complete, or if we did not create the information. If we deny your request, we will provide you a written explanation of our decision. We also will explain your rights regarding having your request and our response included with all future disclosures of your PHI.
- **To Obtain an Accounting of our Disclosures.** You have the right to receive a listing from us of all instances in which we or our business associates have disclosed your PHI for purposes other than treatment, payment, health care operations, or as authorized by you. This list will include only those disclosures made since April 14, 2003 and will only go back six years. The accounting will tell you the date we made the disclosure, the name of the person or entity to whom the disclosure was made, a description of the PHI that was disclosed, and the reason for the disclosure. There may be a charge for accounting disclosures if requested more than once a year.
- **To Request Alternative Communications.** You have the right to ask us to communicate with you about your confidential information by a different method or at another location. We will accommodate all reasonable requests.
- **To Receive Notice.** You are entitled to receive a copy of this notice that outlines our HIPAA privacy practices. We reserve the right to change these practices and the terms of this notice at any time. We will not make any material changes to our privacy practices without first sending you a revised notice. If you receive this notice on our website or by electronic mail, you may request a paper copy.

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

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

Mailing Address: Assurant Employee Benefits  
 Privacy Officer  
 P.O. Box 419052  
 Kansas City, MO 64141- 6052

Telephone: 800.733.7879  
 Email: PrivacyOffice.AEB@assurant.com  
 Web Site: www.assurantemployeebenefits.com

**V. Organizations Covered by This Notice**

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

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

**\* In this notice, “we”, “us”, and “our” refer to Union Security Insurance Company, and the following prepaid dental companies:** DentiCare of Alabama, Inc., Union Security DentalCare of Georgia, 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., Union Security DentalCare of New Jersey, Inc.