



EVIDENCE OF COVERAGE

ARTICLE I DEFINITIONS

- 1.1 **Copayment:** Shall mean an additional fee charged to Member by Plan Provider as identified in the Copayment Schedule.
- 1.2 **Dependent:** Shall mean the spouse of any Subscriber and all newborn infants from and after the moment of birth, natural children, adopted children from the date of placement, stepchildren and foster children under age nineteen (19) who are unmarried and chiefly dependent on Subscriber for support and live in Plan Service Area. Dependents shall be eligible for coverage on the day Subscriber is eligible for coverage or on the day Subscriber acquires such Dependent, whichever is later. Eligibility may be extended up to age twenty-eight (28) for unmarried children who are 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.
- 1.3 **Effective Date for a Member:** The date when coverage begins under Agreement.
- 1.4 **Emergency Services:** Shall mean bona fide emergency services, including necessary palliative treatment, provided after sudden onset of a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate dental attention could reasonably be expected to result in serious jeopardy to the patients dental health.
- 1.5 **Member:** Shall mean a Subscriber or Dependent enrolled in Plan.
- 1.6 **Group:** Shall mean the employer, association, or other organization identified in Agreement.
- 1.7 **Plan Dentist:** Shall mean a General Dentist who is under contract with Plan and responsible for providing dental services to Members of Plan.
- 1.8 **Plan Provider:** Shall mean a Plan Dentist or Plan Specialist under contract with Plan. The term shall include any hygienists and technicians recognized by the dental profession who act with and assist Plan Dentist or 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.
- 1.9 **Plan Specialist:** Shall mean a dentist practicing in a dental specialty under contract with Plan to provide specialty services to Members including, but not limited to, Endodontics, Orthodontics, Pedodontics, Periodontics and Oral Surgery.
- 1.10 **Plan Benefits:** Shall mean the services provided under Agreement, subject to any limitations and exclusions.
- 1.11 **Prepayment Fee:** Shall mean the monthly fee paid by Group to Plan for each Member, including administrative or other fees necessary for provision of coverage.
- 1.12 **Service Area:** Shall mean the area where Plan is licensed to provide Plan Benefits.

- 1.13 **Subscriber:** Shall mean an employee, member or beneficiary of Group who is eligible to participate in Plan under the eligibility requirements determined by Group.

ARTICLE II ELIGIBILITY AND EFFECTIVE DATE

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

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

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

ARTICLE III SUBSCRIBER COPAYMENTS

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

ARTICLE IV BENEFITS AND COVERAGES

- 4.1 **Assignment of Benefits:** Members coverage is intended for the sole use and benefit of Member and cannot be transferred to a third party.
- 4.2 **Plan Benefits:** Plan shall provide dental services in the following areas: appointments, diagnostics, preventative dentistry, restorative dentistry, endodontics, periodontics, removable prosthodontics, fixed prosthodontics and oral surgery to Members. Specific service treatment descriptions are set forth in the Copayment Schedule. Services are subject to limitations and exclusions. Services are provided for the term of Agreement. Plan reserves the right to change Plan Benefits after the initial Plan Year. Notice of change is subject to sixty (60) days written notice.
- 4.3 **Provision of Plan Benefits/Plan Providers:** Unless there is a need for Emergency Services, Agreement provides only for services performed by a Plan Provider. Plan shall not have any liability due to treatment by any non-Plan dentist or physician. In addition, Plan shall not have any liability due to treatment by hospital, other person, institution or group. Each Member shall select a Plan Dentist from the Plan Dentist Directory furnished by Group to Member. Specialty services covered by Plan may be obtained from a Plan Specialist. Agreement provides for services only. It is not an insurance policy. It does not reimburse Member or Group in cash except as required for Emergency Services.
- 4.4 **Selection of Provider:**
- A. Plan Dentist: Each Member shall select a Plan Dentist from Plan Dentist Directory. To obtain Plan

Benefits, Member shall contact selected Plan Dentist and schedule an appointment.

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. Change requests may be delayed until Member pays all monies owed selected Plan Dentist. Any Member who changes selected Plan Dentist without notifying Plan shall be denied coverage for services provided by non-selected Plan Dentist.

B. Plan Specialist: If Member requires specialist services that cannot be provided by Member's selected Plan Dentist, Member may obtain services from a Plan Specialist. No referral from selected Plan Dentist is needed. Plan does not cover services received from specialists not participating with Plan.

4.5 **Member/Plan Provider Relationship:** The relationship between Member and Plan Provider shall be an independent professional one. Plan Provider shall be solely responsible, without interference from Plan or Group for all services within the professional relationship between Member and Plan Provider. Plan 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 proper Copayments, including any missed appointment fees or charges for non covered procedures; (4) uses the relationship for illegal purposes; or (5) otherwise makes the professional relationship unduly burdensome.

ARTICLE V LIMITATIONS AND EXCLUSIONS

This Agreement contains no exclusions for pre-existing conditions.

1. Medical costs associated with dental procedures are not covered.
2. The parent or guardian is responsible for affecting behavior of dependents so that provider may safely render proper dental care. Services rendered by a specialist because of behavior adjustment may affect Member's out of pocket expense. Such services needed may be physical restraint, sedation or other method of control.
3. Dentures or appliances will be replaced only after five years since dentures or appliances were provided by Plan. If denture or appliance becomes unserviceable due to illness or causes not controlled by ordinary means, the following will apply: Replacement will be made only if existing denture or appliance cannot be made serviceable.
4. Replacement of dentures, appliances or bridgework due to loss or theft is not covered.
5. Dental treatment provided or started prior to Members eligibility to receive benefits is not covered. Dental treatment started after Members termination is not covered.
6. Failure to follow prescribed treatment may result in additional charges. Accidents occurring during the course of any treatment may result in additional charges.
7. Restorations and endodontic posts and cores placed after root canal therapy are separate procedures from actual root canal treatment. Therefore, the specific co-payments listed for restorations or posts and cores will apply.
8. Orthodontic Treatment is limited as follows:
 - Minor treatment of tooth guidance/interceptive orthodontia is limited to eighteen (18) consecutive months.
 - Retention treatment is limited to eighteen (18) consecutive months. Ongoing treatment past eighteen (18) consecutive months is not covered. Also, ongoing treatment past eighteen (18) consecutive months may be subject to additional fees. This would be determined as outlined in the Copayment Schedule and determined by provider.
9. Orthodontic treatment involving therapy for myofunctional problems, T.M.J. dysfunctions, micrognathia, macroglossia, cleft palate or hormonal imbalances causing growth and developmental abnormalities, is not covered.
10. Extractions for Orthodontic purposes only are at a 25% discount off of Plan Provider's normal retail charge.
11. Orthodontic cases, involving orthognathic surgery, are not covered.
12. Treatment for malignancies, neoplasms or cysts, including biopsy, is not covered.

13. Services provided by non-Plan dentists are not covered unless preauthorized by Plan.
14. Copayments listed for restorations do not include the cost of lab fees.
15. Restorations and splints used to increase vertical dimension, restore occlusion, or replace/stabilize tooth structure loss by attrition are not covered.
16. Fixed prosthetic restoration of six (6) or more existing teeth, when performed as a simple procedure as part of a complete oral rehabilitation or reconstruction is not covered.
17. Complete oral rehabilitation or reconstruction involving replacement of six (6) or more missing teeth using fixed prosthetic restorations and/or appliances is not covered.
18. Dental treatment is not covered if Members general health or physical limitations prevent provider from rendering appropriate dental treatment.
19. Costs associated with prescriptions or over the counter medications are not covered.
20. Implants, surgery for the insertion of implants, all related implant appliances and restorations, removable or fixed, are not covered.
21. 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.
22. Plan payments for services of non-Plan providers are limited to a total of \$2,000.00 per calendar year.

ARTICLE VI EMERGENCY SERVICES

- 6.1 **Emergency Services:** Plan shall arrange for Emergency Services twenty four (24) hours a day, seven (7) days a week.
- A. **Inside Plan Service Area:** If Member is in Plan Service Area and needs Emergency Services, Member should do the following: Contact Members selected Plan Dentist to arrange for Emergency Services. If Members Plan Dentist is unavailable, Member may obtain Emergency Services from any licensed dentist. Plan will reimburse Member for the actual cost of Emergency Services only, subject to any Copayments, limitations and exclusions.
 - B. **Outside Plan Service Area:** If Member is not in Plan Service Area and needs Emergency Services, Member should seek treatment from any licensed dentist. Plan will reimburse Member for the actual cost of Emergency Services, less a twenty-five dollar (\$25.00) administrative charge, subject to any Copayments, limitations and exclusions.
 - C. **Additional Conditions:** Reimbursement for Emergency Services provided by non-Plan dentists is subject to the following additional conditions:
 1. Covered Dental services include only those necessary to relieve acute symptoms of sufficient severity. This includes severe pain, bleeding, swelling, and the like. It also includes acute symptoms of severity, which, within reason, may place Members dental health in serious jeopardy. It includes severity which may cause dysfunction of any bodily organ or part. It includes these cases of severity which last until Member can either: (1) return to Plan Service Area or (2) continue treatment with Plan Dentist.
 2. The Member must notify Plan or Plan Dentist of his condition and the service arrangements within forty-eight (48) hours after provision of Emergency Services. The Member must also return to Plan Dentist for continued services if indicated. It may happen that a Members physical condition does not allow him to notify Plan within the prescribed time. He will need to notify Plan as soon as reasonably possible.
 3. Reimbursement requests must be in writing. Such requests must be received by Plan within sixty (60) days of the date of service for which payment is requested. These requests must include invoices or other evidence of payment.
 4. Failure to furnish proof within the required time shall not nullify or reduce claim. This applies if it was not reasonably possible to give proof within the required time. This is true provided proof is furnished as soon as reasonably possible.

5. If Emergency Services are performed at a hospital or outpatient care facility other than a dentists office, Plan shall pay only applicable dental charges.

**ARTICLE VII
DENTAL CHARGES PAID BY MEMBERS**

- 7.1 Member shall furnish Plan written proof that Member paid provider for covered benefits and services. Plan may reimburse Member. If so it will be without prejudice to Plans right to seek recovery of any payment made by Plan. Requests for reimbursement must be in writing. Such requests must include invoices describing services provided.
 - A. Proof of Charges. If Member is charged for covered benefits, written proof of charges must be furnished to Plan. This must be within sixty (60) days after receipt of benefit.
 - B. Failure to Furnish Proof of Charges. Failure to furnish proof to Plan within the required time shall not nullify or reduce reimbursement. This is true: (1) only if it was not reasonably possible to provide proof within such time and (2) if proof is furnished as soon as reasonably possible.
 - C. Reimbursement of Charges. Reimbursement requests will be processed within thirty (30) days of receipt of request by Plan. This applies unless Member is notified of the need for additional time. If reimbursement is denied, written notice shall be given to Member. Such notice will contain the reasons for denial.
 - D. Review. Member may obtain a review of the denial through Plans Member Appeals Process.
 - E. Limitations of Actions.
 1. No action at law or equity shall be brought under this Section against Plan prior to the end of a ninety (90) day period. This ninety (90) day period follows the date on which written proof of the charge or loss has been furnished to Plan, or later than three (3) years after the ending of the period of time in which such proof of charge or loss must be furnished to Plan.
 2. No liability shall be imposed upon Plan other than for benefits covered herein.

**ARTICLE VIII
COORDINATION OF BENEFITS**

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

Plan is primary under the following conditions:

1. If Member has coverage under more than one managed care plan, the plan that covers the individual as Member or 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.

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

ARTICLE IX MEMBER APPEALS PROCESS

- 9.1 **Resolution Procedures:** Any inquiry, complaint or grievance shall be made by contacting Plan or Plan Provider. Or Member may contact the Florida Department of Insurance for assistance, at any time, by calling the consumer hotline (1-800-342-2762) or by addressing mail to 200 East Gaines Street, Larson Building, Tallahassee, Florida 32399-0300. Plan inquiries or dissatisfactions may be conveyed by telephone or in writing.

Definition: A complaint is defined as any dissatisfaction regarding any aspect of the companys operation. This includes dissatisfaction with plan administration; appeal of an adverse determination; a denial, reduction or termination of a service; the way a service is provided; or disenrollment decisions. Any such complaint, or grievance, will be considered informal if it is received verbally. A grievance will not be considered formal until it is received by Plan in writing.

- A. **Informal Grievance:** Member may contact Plan Customer Service department at 1-800-443-2995 regarding any inquiry, complaint or grievance that cannot be resolved to Members satisfaction. Plan Customer Service Representative will assess and resolve Members concern. If Member is not satisfied with the resolution, Member may file a written complaint to Plan. Plan Customer Service Representative will provide Member with the guidelines. In addition, such representative will provide complaint form to be completed.
- B. **Formal Grievance:** Plan expects receipt of a completed complaint form or correspondence from Member expressing dissatisfaction with service or care delivered by Plan or Plan Dentist. Any formal grievance may be mailed to: Denticare, Inc., Director of Customer Service, P.O. Box 830626, Birmingham, AL 35283-0626. Plan shall process the written grievance within sixty (60) days. In matters of quality of care or clinical issues, an appropriate health professional will be consulted. If the complaint is not resolved to Members satisfaction, Plan shall provide an appeal procedure.
- C. **Appeal Procedure:** If Member is not satisfied with the resolution of a written complaint, Member may request an appeal of Plans assessment. Upon receipt of an appeal request, Plan will provide Member with Plans written appeal process as defined by Plan or applicable State law.

ARTICLE X TERMINATION

- 10.1 **Termination of Eligibility:** If Subscriber is terminated or leaves Group, Subscriber and his Dependents shall continue to be covered until Plan is notified in writing, by Group, of Subscribers termination.
- 10.2 **Member Termination:** Member coverage may terminate, other than at Groups renewal, for reasons listed below. Termination notice will be given in writing, forty five (45) days prior to the effective date, to the Group. Such notice will stat the reason for termination.
- A. If Member commits fraud or material misrepresentation in applying for or presenting any claim for

benefits under Plan.

- B. If Member ceases to meet eligibility requirements of Group.
- C. If Member fails to make any required prepayment fee or contribution.
- D. If Member misuses Plan documents as evidence of benefits available under Plan.
- E. If Member furnishes to Plan incorrect or incomplete information for the purposes of fraudulently obtaining services. This provision will not be enforced after two (2) years from the time Members coverage begins.
- F. If Members behavior is disruptive, unruly, abusive, unlawful, fraudulent or uncooperative to the extent it impairs the Plans ability to provide dental services to other Members. Prior to termination, Plan will attempt to resolve any problems through grievance procedures. Plan will also determine that Members behavior is not due to services provided or mental illness. Plan will document all information related to the problems, resolution efforts and dental conditions.
- G. Coverage for a Dependent child of a Subscriber will terminate when Dependent child reaches limiting age. Coverage shall not terminate while a Dependent child of Subscriber is and continues to be incapable of self-sustaining employment. This is by reason of a disability or physical handicap. Dependent child must be chiefly dependent upon Subscriber for maintenance and support. Subscriber must furnish proof of incapacity and dependency to Plan within thirty one (31) days of the child attaining limiting age and every year thereafter, if requested by Plan.
- H. If Member no longer works or lives in Plan Service Area.

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

- 11.1 **Continuation of Coverage:** If Agreement is terminated, each Plan Provider shall complete all dental procedures started prior to the date of termination. This is pursuant to the terms of Agreement and as required by state law, except for orthodontia treatment. Should a Member in orthodontia treatment terminate for any reason, Member shall be responsible for payment of services rendered after the termination date.
- 11.2 **Conversion Privilege:** If any Subscriber or Dependent of a Subscriber ceases to meet eligibility requirements of Group and has been continuously covered under Plan for at least 3 months, he may convert to an individual dental plan. This occurs without furnishing evidence of insurability. In order to obtain an individual plan, Member must submit a completed individual enrollment form and all required Prepayment Fees to Plan within thirty one (31) days after termination date. Plan will notify Member in writing of coverage effective date. Conversion privileges shall not be made available to any Member who terminated due to :
 - failure to pay required prepayment fee or contribution,
 - fraud or material misrepresentation in applying for benefits under the Group Agreement,
 - Willful and knowing misuse of Plan identification or documents,
 - Willful and knowing furnishing to Plan incorrect or incomplete information to obtain coverage from Plan,
 - No longer working or residing in the Plan Service Area,
 - Disruptive, unruly, abusive or uncooperative behavior that impaired Plans ability to furnish services to other Members,
 - Or to any Member who will have similar replacement coverage within 31 days.
- 11.3 **Continuation of Coverage under COBRA:** If under the provisions of Title X of the

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

**ARTICLE XII
GENERAL PROVISIONS**

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

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

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Copayment Schedule with Specialty Benefits



Benefits provided by

Dentcare, Inc. (A Prepaid Limited Health Service Organization Licensed Under Chapter 636 of the Florida Statutes)
8130 Baymeadows Way West, Suite 200
Jacksonville, FL 32245-7577 800 443-2995

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

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

Payment for all services received from a non-Plan Dentist will be the responsibility of Member.

ADA Code	Service Description	Member Copayment
Appointments		
999	Routine Office Visit	5.00
120	Periodic Oral Evaluation	No Charge
140	Limited Oral Evaluation Problem Focused (emergency office visit, normal hours)	20.00
9440	Emergency Office Visit (after regularly scheduled office hours)	40.00
150	Comprehensive Oral Evaluation	No Charge
Diagnostic Dentistry		
210	X-Ray - Intraoral, Complete Series, Including Bitewings	No Charge
220	X-Ray - Intraoral, Periapical, First Film	No Charge
230	X-Ray - Intraoral, Periapical, Each Additional Film	No Charge
240	X-Ray - Intraoral, Occlusal	No Charge
250	X-Ray - Extraoral, First Film	No Charge
260	X-Ray - Extraoral, Each Additional Film	No Charge
270	X-Ray - Bitewing Single Film	No Charge
272	X-Ray - Bitewing Two Films	No Charge
274	X-Ray - Bitewing Four Films	No Charge
330	X-Ray - Panoramic Film	No Charge
415	Bacterial Studies	No Charge
425	Caries Susceptibility Tests	No Charge
460	Pulp Vitality Tests	No Charge
9999	Missed Appointment without 24-Hour Notice	20.00
Preventive Dentistry		
1110	Routine Prophylaxis/Cleaning - Adult (once every 6 mos.)	No Charge
1120	Routine Prophylaxis/Cleaning - Child up to age 18 (once every 6 mos.)	No Charge
1203	Topical Application of Fluoride - Child up to age 18 (Prophylaxis/cleaning not included)	No Charge
1310	Nutritional Counseling	No Charge
1330	Oral Hygiene Instruction	No Charge
Diagnostic Dentistry		
1351	Application of Sealant, Per Tooth	10.00
1510	Space Maintainer (Fixed) - Unilateral*	50.00
1515	Space Maintainer (Fixed) - Bilateral*	50.00
1520	Space Maintainer (Removable) - Unilateral*	85.00
1525	Space Maintainer (Removable) - Bilateral*	85.00
1550	Recement Space Maintainer	15.00
1999	Additional Routine Prophylaxis/Cleaning (Routine cleaning does not apply to patients with periodontal disease)	20.00

ADA Code	Service Description	Member Copayment
Restorative Dentistry (Fillings/Crowns)		
2110	Amalgam - One Surface, Primary	No Charge
2120	Amalgam - Two Surfaces, Primary	No Charge
2130	Amalgam - Three Surfaces, Primary	No Charge
2131	Amalgam - Four or More Surfaces, Primary	No Charge
2140	Amalgam - One Surface, Permanent	No Charge
2150	Amalgam - Two Surfaces, Permanent	No Charge
2160	Amalgam - Three Surfaces, Permanent	No Charge
2161	Amalgam - Four or More Surfaces, Permanent	No Charge
2330	Resin Filling - One Surface, Anterior	20.00
2331	Resin Filling - Two Surfaces, Anterior	30.00
2332	Resin Filling - Three Surfaces, Anterior	40.00
2335	Resin Filling - Four or More Surfaces, Anterior	50.00
2385	Resin Filling - One Surface, Posterior, Permanent	50.00
2386	Resin Filling - Two Surfaces, Posterior, Permanent	70.00
2387	Resin Filling - Three or More Surfaces, Posterior, Permanent	85.00
2510	Inlay - Metallic, One Surface*	90.00
2520	Inlay - Metallic, Two Surfaces*	100.00
2530	Inlay - Metallic, Three or More Surfaces*	125.00
2543	Onlay - Metallic, Three Surfaces*	200.00
2544	Onlay - Metallic, Four or More Surfaces*	220.00
2610	Inlay - Porcelain/Ceramic, One Surface*	190.00
2620	Inlay - Porcelain/Ceramic, Two Surfaces*	200.00
2630	Inlay - Porcelain/Ceramic, Three or More Surfaces*	210.00
2740	Crown - Porcelain/Ceramic*	245.00
2750	Crown - Porcelain fused to High Noble Metal*	245.00
2751	Crown - Porcelain to Base Metal*	245.00
2752	Crown - Porcelain to Noble Metal*	245.00
2790	Crown - Full Cast High Noble Metal*	245.00
2791	Crown - Full Cast Base Metal*	245.00
2792	Crown - Full Cast Noble Metal*	245.00
2810	Crown - 3/4 Cast Metallic*	245.00
2910	Recement Inlay	15.00
2920	Recement Crown	15.00
2930	Prefabricated Stainless Steel Crown - Primary Tooth	65.00
2940	Sedative Filling	5.00
2950	Core Buildup, Including Any Pins	75.00
2951	Pin Retention - Per Tooth in Addition to Restoration	10.00
2952	Cast Post and Core, in Addition to Crown*	75.00
2954	Prefabricated Post and Core, in Addition to Crown	75.00
2960	Labial Veneer (Laminate) Chairside	225.00
2962	Labial Veneer (Porcelain Laminate) Lab*	315.00
2980	Repair Crown*	25.00
2999	Temporary Filling	10.00
2999	Cosmetic Bleaching, Per Arch	150.00
2999	Cosmetic Bleaching, Both Arches	250.00
Endodontics (Root Canals)		
3110	Pulp Cap Direct	15.00
3120	Pulp Cap Indirect	No Charge
3220	Pulpotomy	25.00
3310	Root Canal - Anterior (excluding final restoration)	110.00
3320	Root Canal - Bicuspid (excluding final restoration)	185.00

ADA Code	Service Description	Member Copayment
3330	Root Canal - Molar (excluding final restoration)	220.00
3346	Retreatment of Previous Root Canal Therapy Anterior.	320.00
3347	Retreatment of Previous Root Canal Therapy - Bicuspid.	380.00
3348	Retreatment of Previous Root Canal Therapy - Molar.	455.00
3410	Apicoectomy Anterior	55.00
3421	Apicoectomy - Bicuspid, First Root	80.00
3425	Apicoectomy - Molar, First Root	100.00
3426	Apicoectomy - Each Additional Root	45.00
3430	Retrograde Filling - Per Root	30.00
3450	Root Amputation - Per Root	70.00
3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	75.00
Periodontics		
4210	Gingivectomy or Gingivoplasty, Per Quadrant	100.00
4220	Gingival Curettage, Per Quadrant	65.00
4260	Osseous Surgery, Per Quadrant	300.00
4320	Provisional Splinting Intracoronal	50.00
4321	Provisional Splinting Extracoronal	75.00
4341	Periodontal Scaling and Root Planing, Per Quadrant	50.00
4355	Full Mouth Debridement (Complicated Cleaning)	60.00
4910	Periodontal Maintenance Procedures	45.00
4999	Periodontal Hygiene Instruction	No Charge
4999	Periodontal Charting for Planning Treatment of Periodontal Disease	12.00
Removable Prosthodontics (Dentures)		
5110	Complete Upper Denture*	295.00
5120	Complete Lower Denture*	295.00
5130	Immediate Upper Denture (Excluding Reline)*	355.00
5140	Immediate Lower Denture (Excluding Reline)*	355.00
5211	Partial Denture - Upper Resin Base, Including Clasps, etc.*	295.00
5212	Partial Denture - Lower Resin Base, Including Clasps, etc.*	295.00
5213	Partial Denture Upper Cast Metal Framework/Acrylic Base*	375.00
5214	Partial Denture Lower Cast Metal Framework/Acrylic Base*	375.00
5410	Adjust Complete Denture Upper	10.00
5411	Adjust Complete Denture Lower	10.00
5421	Adjust Partial Denture Upper	10.00
5422	Adjust Partial Denture Lower	10.00
5510	Repair Broken Complete Denture Base*	25.00
5610	Repair Resin Denture Base*	35.00
5620	Repair Cast Framework*	35.00
5630	Repair or Replace Broken Clasps	35.00
5640	Repair Broken Teeth - Per Tooth	35.00
5650	Add Tooth to Existing Partial Denture	35.00
5730	Reline Complete Upper Denture Chairside	60.00
5731	Reline Complete Lower Denture Chairside	60.00
5740	Reline Upper Partial Denture Chairside	60.00
5741	Reline Lower Partial Denture Chairside	60.00
5750	Reline Complete Upper Denture - Lab*	95.00
5751	Reline Complete Lower Denture - Lab*	95.00
5760	Reline Upper Partial Denture - Lab*	95.00
5761	Reline Lower Partial Denture - Lab*	95.00
5850	Tissue Conditioning - Upper Denture	20.00
5851	Tissue Conditioning - Lower Denture	20.00
5862	Precision Attachment, by Report*	150.00

ADA Code	Service Description	Member Copayment
Fixed Prosthodontics		
6210	Pontic - Cast High Noble Metal, Per Unit*	245.00
6211	Pontic - Cast Base Metal, Per Unit*	245.00
6212	Pontic - Cast Noble Metal, Per Unit*	245.00
6240	Pontic - Porcelain Fused to High Noble Metal, Per Unit*	245.00
6241	Pontic - Porcelain Fused to Base Metal, Per Unit*	245.00
6242	Pontic - Porcelain Fused to Noble Metal, Per Unit*	245.00
6251	Pontic - Resin with Base Metal, Per Unit*	245.00
6545	Resin Bonded Retainer, Per Unit*	115.00
6721	Crown - Resin with Base Metal, Per Unit*	245.00
6750	Crown - Porcelain Fused to High Noble Metal, Per Unit*	245.00
6751	Crown - Porcelain Fused to Base Metal, Per Unit*	245.00
6752	Crown - Porcelain Fused to Noble Metal, Per Unit*	245.00
6780	Crown - 3/4 Cast High Noble Metal, Per Unit*	245.00
6790	Crown - Full Cast High Noble Metal, Per Unit*	245.00
6791	Crown - Full Cast Base Metal, Per Unit*	245.00
6792	Crown - Full Cast Noble Metal, Per Unit*	245.00
6930	Recement Bridge	15.00
6940	Stress Breaker	150.00
6950	Precision Attachment	150.00
6980	Bridge Repair*	45.00
6999	Resin Bonded Bridge Pontic, Per Unit*	235.00
Oral Surgery		
7110	Single Tooth Extraction	5.00
7120	Each Additional Tooth Extraction, Per Visit	10.00
7130	Root Removal - Exposed Roots	20.00
7210	Surgical Removal of Erupted Tooth	50.00
7220	Removal of Impacted Tooth - Soft Tissue	60.00
7230	Removal of Impacted Tooth - Partial Bony	70.00
7240	Removal of Impacted Tooth - Complete Bony	80.00
7241	Removal of Impacted Tooth - Complete Bony, with Complications	110.00
7250	Surgical Removal of Residual Roots (Cutting Procedure)	30.00
7270	Tooth Reimplantation/Stabilization	40.00
7281	Surgical Exposure, Per Tooth	50.00
7310	Alveoloplasty in Conjunction With Extractions, Per Quadrant	45.00
7320	Alveoloplasty Not in Conjunction with Extractions, Per Quadrant	45.00
7470	Removal of Exostosis	75.00
7510	Incision and Drainage of Abscess Intraoral	25.00
7910	Suture of Small Wound up to 5 cm.	10.00
7960	Frenectomy	55.00
Other Services		
9220	General Anesthesia (first 30 minutes)	180.00
9230	Analgesia - Nitrous Oxide (per 30 minutes)	15.00
9240	IV Sedation	180.00
9310	Consultation Appoint.	94.00
9940	Occlusal Guards	90.00
9951	Occlusal Adjustment Limited	30.00
9952	Occlusal Adjustment Complete	150.00

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

2. SPECIALIST SERVICES (subject to Limitations and Exclusions listed in the Evidence of Coverage):

Should Member require dental services that his selected Plan Dentist is unable to provide, he may obtain those services from a Plan Specialist. No referral is needed from the selected Plan Dentist in order for Member to obtain services from a Plan Specialist. Member responsibilities for obtaining services from a Plan Specialist are outlined below.

Payment for all services received from a non-Plan Specialist will be the responsibility of the Member

(1) On Copayment Schedule (subject to Limitations and Exclusions listed in the Evidence of Coverage):

The following Copayment Schedule applies to covered services when they are provided by a Plan Specialist. If Member receives a service listed on the schedule, he will be responsible for paying the amount in "Member Copayment" column at the time the service is received, or in accordance with Plan Specialist's billing procedures.

ADA Codes	Service Description	Member Copayment
00140	Limited Oral Evaluation, Problem Focused	25.00
00150	Comprehensive Oral Evaluation	25.00
03320	Root Canal Bicuspid (excluding final restoration)	235.00
03330	Root Canal Molar (excluding final restoration)	320.00
03346	Retreatment of Previous Root Canal Therapy - Anterior	335.00
03347	Retreatment of Previous Root Canal Therapy - Bicuspid	430.00
03348	Retreatment of Previous Root Canal Therapy - Molar	475.00
03410	Apicoectomy Anterior	200.00
03421	Apicoectomy Bicuspid, First Root	230.00
03425	Apicoectomy Molar, First Root	265.00
03430	Retrograde Filling - Per Root	65.00
04210	Gingivoplasty, Per Quadrant	225.00
04220	Gingival Curretage, Per Quadrant	90.00
04260	Osseous Surgery, Per Quadrant	390.00
04341	Scaling and Root Planing, Per Quadrant	80.00
04355	Full Mouth Debridement	55.00
04381	Local Delivery of Chemotherapeutic Agents, Per Tooth	60.00
07210	Surgical Removal of Erupted Tooth	60.00
07220	Removal of Impacted Tooth - Soft Tissue	80.00
07230	Removal of Impacted Tooth - Partial Bony	105.00
07240	Removal of Impacted Tooth - Complete Bony	150.00
07241	Removal of Impacted Tooth - Complete Bony with Complications	160.00
07250	Surgical Rem Root	60.00
07281	Surgical Exp	150.00
07310	Alveoloplasty	100.00
07320	Alveoloplasty	85.00
07470	Rem Exostosis	220.00
07510	Incision and Drain	70.00
07960	Frenectomy	145.00
09240	Intravenous Sedation	130.00

(2) Not on Copayment Schedule (subject to Limitations and Exclusions listed in the Evidence of Coverage):

Dental services obtained from a Plan Specialist, but not listed on the schedule above, will be provided to Member at a discount. A 15% discount, off that Plan Specialist's normal retail charges, will be applied to services obtained from a Plan Specialist who is an Endodontist. A 25% discount, off that Plan Specialist's normal retail charges, will be applied to all other services (including orthodontic services) received from a Plan Specialist. Member will be responsible for paying the discounted charge at the time the service is received, or in accordance with Plan Specialist's billing procedures.

HIPAA NOTICE OF PRIVACY PRACTICES

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

I. Our Commitment

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

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

II. Our Use and Disclosure of Your PHI

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

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

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

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

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

III. Your Individual Rights

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

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

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

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

IV. Who to Contact for Questions and Complaints

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

Mailing Address:	Fortis Benefits Insurance Company Privacy Office P.O. Box 419052 Kansas City, MO 64141-6052
Telephone	(800) 733-7879
Email	Mail to: mailto:PrivacyOffice.FBIC@us.fortis.com
Web Site	http://www.fortisbenefits.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 Fortis Benefits Insurance Company; and the following Fortis Benefits DentalCare companies: UDC Life and Health Insurance Company; United Dental Care of Missouri, Inc.; DentiCare of Oklahoma, Inc.; DentiCare of Alabama, Inc.; DentiCare of Arkansas, Inc.; DentiCare, Inc. (A Florida Corporation) A Prepaid Limited Health Service Organization Licensed Under Chapter 636 of the Florida Statutes; DentiCare, Inc. (A Kentucky Corporation); Georgia Dental Plan, Inc.; International Dental Plans, Inc.; Fortis Benefits DentalCare of Wisconsin, Inc.; Fortis Benefits DentalCare of New Jersey, Inc.; UDC Dental California, Inc. dba United Dental Care of California, Inc.; UDC Ohio, Inc. dba United Dental Care of Ohio, Inc.; United Dental Care of Arizona, Inc.; United Dental Care of Colorado, Inc.; United Dental Care of Indiana, Inc.; United Dental Care of Michigan, Inc.; United Dental Care of Nebraska, Inc.; United Dental Care of New Mexico, Inc.; United Dental Care of Pennsylvania, Inc.; United Dental Care of Texas, Inc.; United Dental Care of Utah, Inc.; and United Dental Care Insurance Company.