United Dental Care Insurance Company
450 Devon Avenue, Suite 285
Itasca, Illinois 601473
(800) 443-2995

FORTIS℠

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. 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 services to Members as set forth in the Evidence of Coverage and Copayment Schedule. Services are subject to limitations and exclusions. Services are provided for the term of Agreement. Plan reserves the right to change Plan Benefits after the initial Plan Year. Notice of 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 or Member has Specialty Benefit Amendment coverage, Agreement provides only for services performed by a Plan Provider. Plan shall not have any liability due to treatment by any non-Plan dentist or physician. In addition, Plan shall not have any liability due to treatment by hospital, other person, institution or group. Each Member shall select a Plan Dentist from the Plan Dentist Directory furnished by Group to Member. Specialty services covered by Plan may be obtained from a Plan Specialist or non-Plan specialist. Agreement provides for services only. It is not an insurance policy. It does not reimburse Member or Group in cash except for: (a) Emergency Services or (b) Specialty Benefit Amendment services.

4.4 **Selection of Provider:**

A. Plan Dentist:Each Member shall select a Plan Dentist from Plan Dentist Directory. To obtain Plan Benefits, Member shall contact selected Plan Dentist.

Change of Selected Plan Dentist: Member or Plan Dentist may request a change of Plan Provider selection by contacting Plan. Change requests received by the 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. Specialist: If Member requires specialist services that cannot be provided by Member's selected Plan Dentist, Member may obtain services from a Plan Specialist or a non-participating specialist. No referral is needed from selected Plan Dentist to obtain services from any specialist. Member's out-of-pocket amount will vary depending on whether services are received from a Plan Specialist or a non-Plan specialist.

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.

4.6 **Providers not participating with Plan:** Plan does not review practice standards of non-Plan Providers. Members who obtain services from non-Plan Providers should separately assess the practice standards and skills of those providers.

ARTICLE V
LIMITATIONS AND EXCLUSIONS

1. Medical costs associated with dental procedures are not covered.
2. 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
MEMBER APPEALS PROCESS

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

Definition: A complaint is defined as any dissatisfaction, expressed by Member orally or in writing to Plan regarding any aspect of the companys operation. This includes dissatisfaction with plan administration; appeal of an adverse determination; the denial, reduction or termination of a service; the way a service is provided; or disenrollment decisions.

A. Verbal Complaint: Member may contact Plan Customer Service department regarding any inquiry, complaint or grievance that cannot be resolved to Members satisfaction. This occurs after speaking directly with the dentist or other concerned party. Plan Customer Service Representative will assess and resolve Members concern. If Member is not satisfied with the resolution, Member may file a written complaint to Plan. Plan Customer Service Representative will provide Member with the guidelines. In addition, such representative will provide complaint form to be completed.

B. Written Complaint: Plan expects receipt of a completed complaint form or correspondence from Member expressing dissatisfaction with service or care delivered by Plan or Plan Dentist. Once this occurs, Plan will acknowledge the written complaint within five (5) business days. Plan will

investigate the complaint and will provide a written resolution to Member within (30) calendar days. In matters of quality of care or clinical issues, an appropriate health professional will be consulted. If the complaint is not resolved to Members satisfaction, Plan shall provide an appeal procedure.

C. Appeal Procedure: If Member is not satisfied with the resolution of a written complaint, Member may request an appeal of Plans assessment. Upon receipt of an appeal request, Plan will provide Member with Plans written appeal process as defined by Plan or applicable State law. A Member may resolve complaints by taking the steps outlined. If the complaint cannot be resolved to the Members satisfaction, the Member may contact the Illinois Department of Insurance, Consumer Division of Public Services, 320 West Washington Street, Springfield, Illinois 62767.

ARTICLE IX
TERMINATION

9.1 **Termination of Eligibility:** If Subscriber is terminated or leaves Group, Subscriber and his Dependents shall continue to be covered until Plan is notified in writing of Subscribers termination.

9.2 **Member Termination:** Member coverage shall terminate as follows:

A. On the last day of the month for which Group has placed Member on eligibility list and paid the proper Prepayment Fee.

B. If Member ceases to meet eligibility requirements of Group, coverage will terminate on the next Prepayment Fee due date, subject to the individual conversion privilege, if available.

C. If Member commits fraud or material misrepresentation in the use of services or facilities, coverage for Member will terminate immediately upon written notice.

D. If Member commits fraud or material misrepresentation on the Enrollment Form, coverage will terminate immediately upon written notice. This provision will not be enforced after two (2) years from the time Members coverage began.

E. If Group or Plan terminates Agreement, coverage for Member shall cease on the termination date. This shall be subject to any notice required by state law.

F. If Member fails to make required payments, Plan reserves the right to terminate coverage upon sixty (60) days written notice. Such payments include Copayments and missed appointment fees. Prepayment Fees received for terminated Member for the period after termination date shall be refunded to Group. Thereafter, Plan shall have no further liability or responsibility to Member.

G. A Member, after reasonable efforts, may be unable to establish a satisfactory dentist-patient relationship with a Plan Provider. If so, Plan reserves the right to terminate coverage upon sixty (60) days written notice. Prepayment Fees received for terminated Member for the period after termination date shall be refunded to Group. Thereafter, Plan shall have no further liability or responsibility to Member.

H. Coverage for Subscribers Dependents will be terminated if the coverage for Subscriber terminates for any reason. This is subject to continuation privileges for certain Dependents as set forth herein.

I. Once a Member is no longer qualified as a Dependent, coverage for that Member will terminate. Coverage shall not terminate while a Dependent child of Subscriber is and continues to be incapable of self-sustaining employment. This is by reason of a disability or physical handicap. Dependent must be chiefly dependent on the Subscriber for maintenance and support. Subscriber must furnish proof of incapacity and dependency to Plan. This must occur within thirty-one (31) days of the child attaining limiting age. This also must occur every year thereafter, if requested by Plan.

J. A Member may have fulfilled his obligations under Plan for one (1) year. If so, Member may elect to terminate coverage by giving thirty (30) days written notice to Group.

K. If Member no longer works or lives in Plan Service Area.

ARTICLE X
CONTINUATION OF COVERAGE / CONVERSION / COBRA

10.1 **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.

10.2 **Conversion Privilege:** If Member ceases to meet eligibility requirements of Group, Member may convert to an individual dental plan, if available. This occurs without furnishing evidence of insurability. In order to obtain an individual dental plan, Member must work or live in Plan Service Area. He must submit a completed individual enrollment form and all Prepayment Fees to Plan within thirty-one (31) days after termination date. Plan will notify Member in writing of coverage effective date. Conversion privileges shall not be made available to Member terminated as a result of fraud or material misrepresentation.

10.3 **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 XI
GENERAL PROVISIONS

11.1 **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.

11.2 **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.

11.3 **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.

11.4 **Major Disaster or Epidemic:** If a major disaster or epidemic occurs, Plan Provider shall render dental services as practical according to his judgment. Such disaster or epidemic may limit available facilities or personnel. In such situation, neither Plan nor Plan Provider shall have any liability or obligation for delay or failure to provide dental services.

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

Copayment Schedule with Specialty Benefits

Benefits provided by

United Dental Care Insurance Company
450 Devon Avenue, Suite 285
Itasca, Illinois 60143
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 Prophy/Cleaning - Adult (once every 6 mos.)	7.00
1120	Routine Prophy/Cleaning - Child up to age 18 (once every 6 mos.)	6.00
1203	Topical Application of Fluoride - Child up to age 18 (Prophy/cleaning not included)	No Charge
1310	Nutritional Counseling	No Charge
1330	Oral Hygiene Instruction	No Charge
	Diagnostic Dentistry	
1351	Application of Sealant, Per Tooth	6.00
1510	Space Maintainer (Fixed) - Unilateral*	60.00
1515	Space Maintainer (Fixed) - Bilateral*	60.00
1520	Space Maintainer (Removable) - Unilateral*	60.00
1525	Space Maintainer (Removable) - Bilateral*	60.00
1550	Recement Space Maintainer	15.00
1999	Additional Routine Prophy/Cleaning (Routine cleaning does not apply to patients with periodontal disease)	25.00

ADA Code	Service Description	Member Copayment
	Restorative Dentistry (Fillings/Crowns)	
2110	Amalgam - One Surface, Primary	12.00
2120	Amalgam - Two Surfaces, Primary	20.00
2130	Amalgam - Three Surfaces, Primary	20.00
2131	Amalgam - Four or More Surfaces, Primary	25.00
2140	Amalgam - One Surface, Permanent	13.00
2150	Amalgam - Two Surfaces, Permanent	18.00
2160	Amalgam - Three Surfaces, Permanent	22.00
2161	Amalgam - Four or More Surfaces, Permanent	30.00
2330	Resin Filling - One Surface, Anterior	25.00
2331	Resin Filling - Two Surfaces, Anterior	30.00
2332	Resin Filling - Three Surfaces, Anterior	45.00
2335	Resin Filling - Four or More Surfaces, Anterior	45.00
2385	Resin Filling - One Surface, Posterior, Permanent	40.00
2386	Resin Filling - Two Surfaces, Posterior, Permanent	55.00
2387	Resin Filling - Three or More Surfaces, Posterior, Permanent	70.00
2510	Inlay - Metallic, One Surface*	190.00
2520	Inlay - Metallic, Two Surfaces*	210.00
2530	Inlay - Metallic, Three or More Surfaces*	230.00
2543	Onlay - Metallic, Three Surfaces*	265.00
2544	Onlay - Metallic, Four or More Surfaces*	290.00
2610	Inlay - Porcelain/Ceramic, One Surface*	225.00
2620	Inlay - Porcelain/Ceramic, Two Surfaces*	245.00
2630	Inlay - Porcelain/Ceramic, Three or More Surfaces*	250.00
2740	Crown - Porcelain/Ceramic*	280.00
2750	Crown - Porcelain fused to High Noble Metal*	275.00
2751	Crown - Porcelain to Base Metal*	275.00
2752	Crown - Porcelain to Noble Metal*	275.00
2790	Crown - Full Cast High Noble Metal*	275.00
2791	Crown - Full Cast Base Metal*	275.00
2792	Crown - Full Cast Noble Metal*	275.00
2810	Crown - 3/4 Cast Metallic*	275.00
2910	Recement Inlay	15.00
2920	Recement Crown	15.00
2930	Prefabricated Stainless Steel Crown - Primary Tooth	75.00
2940	Sedative Filling	25.00
2950	Core Buildup, Including Any Pins	75.00
2951	Pin Retention - Per Tooth in Addition to Restoration	20.00
2952	Cast Post and Core, in Addition to Crown*	95.00
2954	Prefabricated Post and Core, in Addition to Crown	80.00
2960	Labial Veneer (Laminate) Chairside	260.00
2962	Labial Veneer (Porcelain Laminate) Lab*	315.00
2980	Repair Crown*	25.00
2999	Temporary Filling	15.00
2999	Cosmetic Bleaching, Per Arch	150.00
2999	Cosmetic Bleaching, Both Arches	300.00
	Endodontics (Root Canals)	
3110	Pulp Cap Direct	10.00
3120	Pulp Cap Indirect	10.00
3220	Pulpotomy	30.00
3310	Root Canal - Anterior (excluding final restoration)	120.00
3320	Root Canal - Bicuspid (excluding final restoration)	130.00

ADA Code	Service Description	Member Copayment
3330	Root Canal - Molar (excluding final restoration)	160.00
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	160.00
3421	Apicoectomy - Bicuspid, First Root	180.00
3425	Apicoectomy - Molar, First Root	200.00
3426	Apicoectomy - Each Additional Root	85.00
3430	Retrograde Filling - Per Root	60.00
3450	Root Amputation - Per Root	100.00
3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	75.00
	Periodontics	
4210	Gingivectomy or Gingivoplasty, Per Quadrant	150.00
4220	Gingival Curettage, Per Quadrant	55.00
4260	Osseous Surgery, Per Quadrant	225.00
4320	Provisional Splinting Intracoronal	75.00
4321	Provisional Splinting Extracoronal	65.00
4341	Periodontal Scaling and Root Planing, Per Quadrant	36.00
4355	Full Mouth Debridement (Complicated Cleaning)	35.00
4910	Periodontal Maintenance Procedures	30.00
4999	Periodontal Hygiene Instruction	No Charge
4999	Periodontal Charting for Planning Treatment of Periodontal Disease	12.00
	Removable Prosthodontics (Dentures)	
5110	Complete Upper Denture*	350.00
5120	Complete Lower Denture*	350.00
5130	Immediate Upper Denture (Excluding Reline)*	410.00
5140	Immediate Lower Denture (Excluding Reline)*	410.00
5211	Partial Denture - Upper Resin Base, Including Clasps, etc.*	375.00
5212	Partial Denture - Lower Resin Base, Including Clasps, etc.*	375.00
5213	Partial Denture Upper Cast Metal Framework/Acrylic Base*	425.00
5214	Partial Denture Lower Cast Metal Framework/Acrylic Base*	425.00
5410	Adjust Complete Denture Upper	15.00
5411	Adjust Complete Denture Lower	15.00
5421	Adjust Partial Denture Upper	15.00
5422	Adjust Partial Denture Lower	15.00
5510	Repair Broken Complete Denture Base*	40.00
5610	Repair Resin Denture Base*	40.00
5620	Repair Cast Framework*	40.00
5630	Repair or Replace Broken Clasps	40.00
5640	Repair Broken Teeth - Per Tooth	40.00
5650	Add Tooth to Existing Partial Denture	40.00
5730	Reline Complete Upper Denture Chairside	80.00
5731	Reline Complete Lower Denture Chairside	80.00
5740	Reline Upper Partial Denture Chairside	80.00
5741	Reline Lower Partial Denture Chairside	80.00
5750	Reline Complete Upper Denture - Lab*	60.00
5751	Reline Complete Lower Denture - Lab*	60.00
5760	Reline Upper Partial Denture - Lab*	60.00
5761	Reline Lower Partial Denture - Lab*	60.00
5850	Tissue Conditioning - Upper Denture	35.00
5851	Tissue Conditioning - Lower Denture	35.00
5862	Precision Attachment, by Report*	150.00

ADA Code	Service Description	Member Copayment
	Fixed Prosthodontics	
6210	Pontic - Cast High Noble Metal, Per Unit*	275.00
6211	Pontic - Cast Base Metal, Per Unit*	275.00
6212	Pontic - Cast Noble Metal, Per Unit*	275.00
6240	Pontic - Porcelain Fused to High Noble Metal, Per Unit*	275.00
6241	Pontic - Porcelain Fused to Base Metal, Per Unit*	275.00
6242	Pontic - Porcelain Fused to Noble Metal, Per Unit*	275.00
6251	Pontic - Resin with Base Metal, Per Unit*	275.00
6545	Resin Bonded Retainer, Per Unit*	140.00
6721	Crown - Resin with Base Metal, Per Unit*	275.00
6750	Crown - Porcelain Fused to High Noble Metal, Per Unit*	275.00
6751	Crown - Porcelain Fused to Base Metal, Per Unit*	275.00
6752	Crown - Porcelain Fused to Noble Metal, Per Unit*	275.00
6780	Crown - 3/4 Cast High Noble Metal, Per Unit*	275.00
6790	Crown - Full Cast High Noble Metal, Per Unit*	275.00
6791	Crown - Full Cast Base Metal, Per Unit*	275.00
6792	Crown - Full Cast Noble Metal, Per Unit*	275.00
6930	Recement Bridge	25.00
6940	Stress Breaker	150.00
6950	Precision Attachment	195.00
6980	Bridge Repair*	50.00
6999	Resin Bonded Bridge Pontic, Per Unit*	235.00
	Oral Surgery	
7110	Single Tooth Extraction	21.00
7120	Each Additional Tooth Extraction, Per Visit	21.00
7130	Root Removal - Exposed Roots	35.00
7210	Surgical Removal of Erupted Tooth	50.00
7220	Removal of Impacted Tooth - Soft Tissue	60.00
7230	Removal of Impacted Tooth - Partial Bony	80.00
7240	Removal of Impacted Tooth - Complete Bony	100.00
7241	Removal of Impacted Tooth - Complete Bony, with Complications	120.00
7250	Surgical Removal of Residual Roots (Cutting Procedure)	50.00
7270	Tooth Reimplantation/Stabilization	60.00
7281	Surgical Exposure, Per Tooth	100.00
7310	Alveoloplasty in Conjunction With Extractions, Per Quadrant	75.00
7320	Alveoloplasty Not in Conjunction with Extractions, Per Quadrant	125.00
7470	Removal of Exostosis	220.00
7510	Incision and Drainage of Abscess Intraoral	55.00
7910	Suture of Small Wound up to 5 cm.	85.00
7960	Frenectomy	120.00
	Other Services	
9220	General Anesthesia (first 30 minutes)	180.00
9230	Analgesia - Nitrous Oxide (per 30 minutes)	10.00
9240	IV Sedation	180.00
9310	Consultation Appoint.	30.00
9940	Occlusal Guards	85.00
9951	Occlusal Adjustment Limited	30.00
9952	Occlusal Adjustment Complete	100.00

*** 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 or a non-Plan Specialist. No referral is needed from the selected Plan Dentist in order for Member to obtain services from the specialist of his choice. However, Member's out-of-pocket amount may vary depending on whether services are received from a Plan Specialist or a non-Plan Specialist. Member responsibilities for obtaining services under either method are outlined below.

A. Plan Specialist Services:

(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	Gingivial 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.

B. Specialist Services received from a non-Plan Specialist (subject to a $2,000.00 limit paid by Plan in any Plan Year):

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

If a Member chooses to receive a dental service listed on the following schedule from a non-Plan Specialist, he will be responsible for paying that specialist's entire normal retail charge for the service at the time the service is received or in accordance with specialist's billing procedures. Member may then submit a completed claim form, with an itemized bill attached, to Plan. (Member may obtain claim forms by contacting Plan.) Plan will pay Member lesser of the amount shown in "Plan Pay" column of the following schedule or the amount charged by specialist for the service.

ADA Codes	Service Description	Plan Payment
00140	Limited Oral Evaluation, Problem Focused	15.00
00150	Comprehensive Oral Evaluation	15.00
03320	Root Canal Bicuspid (excluding final restoration)	265.00
03330	Root Canal Molar (excluding final restoration)	330.00
03346	Retreatment of Previous Root Canal Therapy - Anterior	215.00
03347	Retreatment of Previous Root Canal Therapy - Bicuspid	220.00
03348	Retreatment of Previous Root Canal Therapy - Molar	300.00
03410	Apicoectomy Anterior	250.00
03421	Apicoectomy - Bicuspid, First Root	350.00
03425	Apicoectomy - Molar, First Root	335.00
03430	Retrograde Filling - Per Root	60.00
04210	Gingivoplasty, Per Quadrant	125.00
04220	Gingivial Curretage, Per Quadrant	50.00
04260	Osseous Surgery, Per Quadrant	310.00
04341	Scaling and Root Planing, Per Quadrant	70.00
04355	Full Mouth Debridement	35.00
04381	Local Delivery of Chemotherapeutic Agents, Per Tooth	40.00
07210	Surgical Removal of Erupted Tooth	90.00
07220	Removal of Impacted Tooth Soft Tissue	95.00
07230	Removal of Impacted Tooth Partial Bony	120.00
07240	Removal of Impacted Tooth Complete Bony	100.00
07241	Removal of Impacted Tooth Complete Bony with Complications	130.00
07250	Surgical Removal of Residual Roots	100.00
07281	Surgical Exposure, Per Tooth	110.00
07310	Alveoloplasty in Conjunction with Extractions, Per Quadrant	40.00
07320	Alveoloplasty not in Conjunction with Extractions, Per Quadrant	100.00
07470	Removal of Exostosis	140.00
07510	Incision and Drainage of Abscess - Intraoral	35.00
07960	Frenectomy	115.00
09240	Intravenous Sedation	100.00

(2) Not on Copayment Schedule

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

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 otherthan 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.