UDC Dental California, Inc.
2175 North California Boulevard
Suite 990
Walnut Creek, CA 94596

(800-443-2995)

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

INTRODUCTION TO PLAN

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

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

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

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

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

PRIVACY NOTICE

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

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ARTICLE I
DEFINITIONS

1.1 **Agreement:** Shall mean the contract between the Plan and Group and as defined in Article II of the Group Dental Service Agreement.

1.2 **Copayment:** Shall mean an additional fee charged to Member by Plan Provider, which has been approved by the Director of the Department and identified in the Copayment Schedule.

1.3 **Dependent:** Shall mean the spouse or domestic partner (as defined in Section 297 of the California Family Code) of any Subscriber and all newborn infants from and after the moment of birth, natural children, adopted children from the date of placement, stepchildren or the domestic partner's children, foster children and children whom the Subscriber is required to provide coverage pursuant to a court or administrative order. All such children shall be under age nineteen (19), unmarried and chiefly dependent on a Subscriber for support. Dependent shall be eligible for coverage on the day the Subscriber is eligible for coverage or when he or she attains the status of a dependent, whichever is later.

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

1.4 **Department:** Shall mean the California Department of Managed Health Care, which is within the California Business, Transportation and Housing Agency that has charge of the execution of California laws relating to health care service plans and health care service plan business, including, but not limited to, those laws directing the department to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interest of members.

1.5 **Effective Date:** The date coverage begins under Agreement.

1.6 **Emergency Dental Services:** Shall mean those dental services a layperson reasonably believes are required for alleviation of severe pain, bleeding, swelling, or immediate diagnosis and treatment of unforeseen dental conditions which, if not treated, could reasonably be expected to result in placing a Member's dental health in serious jeopardy even if it is later discovered that a dental emergency did not exist. If Member requires emergency medical care, Member should immediately call 9-1-1 or seek immediate care at the closest hospital or trauma center.

1.7 **Exclusion:** Shall mean a dental service or treatment that is not a Plan Benefit.

1.8 **Limitation:** Shall mean a dental service or treatment that is restricted by the Plan.

1.9 **Member:** Shall mean a Subscriber or Dependent who is enrolled in Plan.

1.10 **Group:** Shall mean the employer, association or other organization identified in Agreement.

1.11 **Plan Dentist:** Shall mean a California licensed dentist who is under contract with Plan and responsible for providing Plan Benefits to Members of Plan.

1.12 **Plan Dentist Directory:** Shall mean the list of Plan Dentists and Plan Specialists with whom the Plan contracts and Members may see to obtain Plan Benefits. Upon request, Plan will forward the Plan Dentist Directory to any Member.

1.13 **Plan Provider:** Shall mean collectively a Plan Dentist or Plan Specialist. The term shall include any hygienists and technicians recognized by the dental profession who act with and assist Plan Dentist or Plan Specialist. Establishment and location of all Plan Providers are within the sole discretion and determination of Plan. A list of Plan Providers shall be published in Plan Dentist Directory.

1.14 **Plan Specialist:** Shall mean a California licensed dentist practicing in a dental specialty under contract with Plan to provide specialty services to Members including endodontics, orthodontics, pedodontics, periodontics and oral surgery.

1.15 **Plan Year:** Agreement's initial Plan Year begins on the Effective Date and lasts for the number of months stated in Agreement. Each subsequent Plan Year of Agreement begins on the Anniversary Date and lasts for a period of twelve (12) calendar months.

1.16 **Plan Benefits:** Shall mean the dental services and treatment provided to Members under Agreement, subject to any limitations and exclusions.

1.17 **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.

1.18 **Prior Plan:** The Group's plan of group dental coverage that was replaced by this Plan.

1.19 **Service Area:** Shall mean the geographic area designated by the Plan and approved by the Department where Plan is licensed to provide Plan Benefits.

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

1.21 **Surcharge:** Shall mean an additional fee which is charged to a Subscriber or Member for a Plan Benefit but which is not approved by the Director of the Department, provided for in this Agreement, and disclosed in the Combined Evidence of Coverage and Disclosure Form.

1.22 **Urgent Services:** Shall mean immediate dental treatment required to prevent serious deterioration of Member's dental health resulting from unforeseen illness or injury for which treatment cannot be delayed until Member returns to the Service Area.

ARTICLE II
ELIGIBILITY, PREPAYMENT FEES AND EFFECTIVE DATE

2.1 **Plan Year:** The initial Plan Year shall begin on the Effective Date and last for a period of (12) consecutive calendar months. Each subsequent Plan Year shall begin on the Anniversary Date and last for a period of twelve (12) consecutive calendar months. The Anniversary Date for this plan is July, 2020.

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

A Dependent shall be eligible for coverage on the day Subscriber is eligible for coverage or when he or she attains the status of a Dependent, whichever is later. All newborn Dependents shall be

eligible for coverage from and after the moment of birth. If an additional Prepayment Fee is required for coverage of a newborn Dependent, Group must notify Plan. Any resulting Prepayment Fee must be paid within thirty-one (31) days after the date of birth.

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

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

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

2.3 **Coverage of Members/Effective Date:** Each Subscriber or Dependent whose Prepayment Fee has been accepted by Plan prior to the 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 AND OTHER CHARGES

3.1 **Copayments:** Member shall be responsible for payment of all Copayments and charges for non-Plan Benefits. Member shall pay applicable Copayment to Plan Provider at the time service is rendered. Member may have an option to pay according to provider's billing procedures. Member should meet with Plan Provider prior to obtaining dental care if the Member is unable to pay the Copayment once treatment is completed.

3.2 **Other Charges:** If a Member desires to receive dental care or services not listed as a Plan Benefit, the Member is financially obligated to pay the Plan Provider for such dental care or treatment.

3.3 **Change in Copayment:** Plan, at Plan's discretion, may change the amount of any required Copayment. Plan shall provide Group with written notice of any change in Copayment amount at least thirty (30) days before any such change takes effect.

ARTICLE IV
DENTAL BENEFITS AND COVERAGES

4.1 **Plan Benefits:** Please refer to the Copayment Schedule, which is attached to this Combined Evidence of Coverage and Disclosure Form, for a complete list of Plan Benefits. Plan shall provide services to Member as set forth in the Combined Evidence of Coverage and Disclosure Form and the Copayment Schedule. Plan Benefits are subject to various limitations and exclusions. Plan Benefits are provided to Members for the term of this Agreement. Plan, at Plan's

discretion, may change the Plan Benefits provided. Plan shall provide Group with written notice of any change in Plan Benefits at least thirty (30) days before any such change takes effect.

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

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

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

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

4.3 **Assignment of Benefits:** Member's coverage is intended for the sole use and benefit of Member and cannot be transferred to a third party.

4.4 **Current Dental Terminology:** The most current dental terminology may not be reflected in Agreement. However, Plan Benefits will be based on the most current dental terminology. From time to time, and with at least thirty (30) days' written notice to Group, Plan reserves the right to update this Evidence of Coverage and Disclosure Form to reflect the most current dental terminology.

ARTICLE V
CHOICE OF PROVIDERS/FACILITIES

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

5.1 **Selection of Provider:** Information on Plan Providers, including names, addresses, and telephone numbers, are available to the Members through the Plan Dentist Directory. Each Member shall select a Plan Dentist from Plan Dentist Directory. To obtain Plan Benefits, Member shall contact the Plan Dentist selected by Member from the Plan Dentist Directory.

A. Change of Selected Plan Dentist: Member or Plan Dentist may request a change of Plan Provider selection by contacting Plan. Change requests received by the 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. Any Member who changes selected Plan Dentist without notifying Plan shall be denied coverage for services provided by non-selected Plan Dentist.

B. Plan Specialist: If Member requires specialty services covered under Plan that cannot be provided by Member's selected Plan Dentist, Member may obtain services from a Plan Specialist. The Member simply contacts the Plan Specialist directly to obtain Plan Benefits. No referral from the selected Plan Dentist or Plan is needed. Except in cases involving Emergency Dental Services, Urgent Services outside of Service Area or reimbursable services provided by a non-Plan Provider (see section 4.2 under Article IV), Plan does not cover services received from non-Plan Providers.

C. Failure to Select a Plan Dentist: The Plan will contact any Member, or his or her representative, who has failed to select a Plan Dentist. The Member will be reminded that it is his or her responsibility to select a Plan Dentists from the Plan Dentist Directory.

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

5.2 **Member/Plan Provider Relationship:** The relationship between Member and Plan Provider shall be an independent professional one. Plan Provider shall be solely responsible, without interference from Plan or Group, for all services within the professional relationship between Member and Plan Provider. Plan or Plan Provider shall have the right to refuse treatment to any Member who: (1) fails to follow a prescribed course of treatment; (2) fails to keep confirmed appointments; (3) fails or refuses to pay Copayments or charges for non-covered procedures; (4) uses the relationship for illegal purposes; or (5) otherwise makes the professional relationship unduly burdensome.

5.3 **Providers Not Participating With Plan:** Plan does not review practice standards of non-Plan Providers. Members who obtain services from non-Plan Providers should separately assess the practice standards and skills of those providers.

5.4 **Plan Provider Facilities:** The operation and maintenance of Plan Provider's facilities and equipment shall be completely under the control of Plan Provider. This includes the selection of staff, supervision of personnel and operation of the professional practice. It also includes rendition of any particular professional service or treatment.

5.5 **Plan Provider Compensation:** Plan compensates Plan Providers in a variety of ways. Providers are paid on a "capitated basis." This means Plan pays a per Member per month fee to the Plan Dentist who provides services to Plan's Members. Also, some Plan Providers may be paid on a discounted fee-forservice basis. This means the Plan reimburses the Plan Provider for the care provided in an amount that is less than what he or she typically charges for dental care. Plan's Providers are always required by Plan to provide services in a quality manner in accordance with detailed regulatory and contractual requirements. These requirements help reduce overall costs by providing quality care emphasizing preventive health care access and utilization of effective treatment methods.

ARTICLE VI
LIMITATIONS AND EXCLUSIONS

LIMITATIONS OF BENEFITS

1. Dentures may be replaced as necessary for the health of the Member as deemed necessary by the Plan Dentist who is providing treatment or evaluation.

2. Orthodontic treatment is limited as follows:

    a) Limited orthodontic treatment of tooth guidance orthodontia is limited to eighteen (18) consecutive months of continuous treatment.

    b) Active orthodontic treatment (from placement of banding/bracketing) is limited to twentyfour (24) consecutive months of continuous treatment and is allowed once per lifetime.

    c) Retention treatment is limited to twelve (12) consecutive months. Ongoing retention treatment past twelve (12) consecutive months may be subject to additional fees as determined by Plan Specialist. Additional fees will be the sole responsibility of the Member.

3. Failure of Member to follow a prescribed course of dental treatment may result in the need for additional dental services. Such dental services may result in additional Copayments and charges for non-Plan Benefits.

4. Copayments listed for fixed prosthetic restorations do not cover the cost of any precious or semiprecious alloy used in their fabrication. This limitation applies to ADA codes 2750, 2752, 2790, 2792, 6210, 6212, 6240, 6242, 6750, 6752, 6790 and 6792. These ADA Codes along with the corresponding Service Descriptions are listed in the Copayment Schedule.

EXCLUSIONS OF BENEFITS

1. Any procedure not specifically listed in the Copayment Schedule is not a Plan Benefit.

2. Any dental service started and completed prior to Effective Date is not covered. Any dental service listed in the Copayment Schedule, started, but not completed prior to the Effective Date, will be considered a Plan Benefit only if completion of the dental service is provided by a Plan Provider. For dental services other than orthodontics, Member will be responsible for the full Copayment amount plus any applicable alloy or precious metals fee for the dental service completed under the Plan. For orthodontic services, Member will be responsible for the full orthodontic Copayment, which will be prorated according to the Plan Provider's plan of treatment and normal billing procedures based on the percentage of orthodontic work completed prior to the Effective Date. Any dental service started after Member's termination is not covered.

3. Treatment for malignancies, neoplasms or cysts, including biopsy, is not covered.

4. Implants, surgery for the insertion of implants, all related implant appliances and restorations, removable or fixed, are not covered.

5. The surgical removal of implants, or any surgery required to adjust, replace, or treat any problem related to an existing implant, or implant appliance, is not covered.

6. Extractions for non-symptomatic third molars (wisdom teeth) are not covered. This exclusion also applies to extractions for non-symptomatic third molars after the completion of orthodontic treatment. Examples of symptomatic conditions include decay, odontogenic cysts, chronic pericoronitis and infection.

7. Complete oral rehabilitation or reconstruction involving replacement of six (6) or more missing teeth using fixed prosthetic restorations and/or appliances is not covered.

8. Restorations and splints used to increase vertical dimension, restore occlusion, or replace/stabilize tooth structure loss by attrition are not covered.

9. Replacement of dentures, appliances or bridgework due to loss or theft is not covered.

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

ARTICLE VII
EMERGENCY DENTAL SERVICES

7.1 **Emergency Dental Services:** Emergency Dental Services are those dental services a layperson reasonably believes are required for alleviation of severe pain, bleeding, swelling, or immediate diagnosis and treatment of unforeseen dental conditions which, if not treated, could reasonably be expected to result in placing a Member's dental health in serious jeopardy even if it is later discovered that a dental emergency did not exist. If Member requires emergency medical care, Member should immediately contact 9-1-1 or go to the nearest trauma center or hospital. Plan shall arrange for Emergency Dental Services twenty four (24) hours a day, seven (7) days a week. A Member may go to any available dentist for treatment of Emergency Dental Services. The Plan includes, as a Plan Benefit, Urgent Services by a non-Plan Provider outside the Service Area. The Member must seek reimbursement from the Plan if he or she receives Emergency Dental Services or Urgent Services outside of the Service Area.

A. Inside Plan Service Area: If Member is in the Service Area and needs Emergency Dental Services, Member must first contact his or her selected Plan Dentist to arrange for Emergency Dental Services. If Member's Plan Dentist is unavailable, Member may obtain Emergency Dental Services from any licensed dentist. Plan will reimburse Member for the actual cost of Emergency Dental Services only, subject to a deduction for any Copayments, limitations and exclusions.

B. Outside Plan Service Area: If Member is not in the Service Area and needs Emergency Dental Services or Urgent Services, Member should seek treatment from any licensed dentist. Plan will reimburse Member for the actual cost of Emergency Dental Services or Urgent Services, subject to a deduction for any Copayments, limitations and exclusions.

C. Additional Conditions: Reimbursement for Emergency Dental Services provided by non-Plan Dentists is subject to the following additional conditions:

1. Plan Benefits include care required for alleviation of severe pain, bleeding, swelling, such that a prudent layperson may believe that urgent or unscheduled dental care is required, even if it is later discovered that an emergency did not in fact exist.

2. The Member must notify Plan or Plan Dentist of his or her condition and the service arrangements within forty-eight (48) hours, or such other reasonable time, given the Member's condition, after provision of Emergency Dental Services. The Member must also return to Plan Dentist for continued services if indicated.

3. Reimbursement requests must be in writing and received by Plan within one (1) year of the date of service for which payment is requested. These requests must include invoices or other evidence of payment.

4. Failure to furnish proof of charges to the Plan within one (1) year from the date Plan Benefits were provided shall not nullify or reduce reimbursement so long as it was not reasonably possible for Member to provide the information and the information is

provided as soon as reasonably possible.

5. If Emergency Dental Services are performed at a hospital or outpatient care facility rather than a dentist's office, Plan shall pay only applicable dental charges. Plan shall not pay for covered Emergency Dental Services if Plan determines that such Emergency Dental Services were never performed.

ARTICLE VIII
REIMBURSEMENT PROVISIONS

8.1 **Reimbursement Provisions:** Member seeking reimbursement from the Plan shall furnish Plan with written proof that Member paid the provider for Plan Benefits. Member requests for reimbursement must be in writing. Such requests must include invoices (or other similar documentation) describing services provided, the name and address of the dentist providing such dental services, and the date such services were performed. If Plan reimburses Member, the Plan may seek recovery of any payment made by Plan for which it is entitled to reimbursement.

A. Proof of Charges: If Member is charged for Plan Benefit, written proof of charges must be furnished to Plan. This must be within sixty (60) days after receipt of benefit.

B. Failure to Furnish Proof of Charges: Failure to furnish proof to Plan within the required time shall not nullify or reduce reimbursement so long as it was not reasonably possible for Member to provide the information and the information is provided as soon as reasonably possible.

C. Reimbursement of Charges: Reimbursement requests will be processed within thirty (30) working days of receipt of the claim. If additional information is needed in order to process a claim, Plan will contact Member within thirty (30) working days of receipt of the claim to request the missing information. Upon receipt of the missing information, Plan will reimburse or deny the claim within thirty (30) working days. If a claim is denied in part or in full, a written notice containing the reason for the denial shall be provided to the Member.

D. Review: Member may obtain a review of the denial through Plan's Member Appeals Process (Article X).

ARTICLE IX
COORDINATION OF BENEFITS

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

Plan is "primary" under the following conditions:

1. If Member has coverage under more than one managed care plan, the plan that covers the individual as Subscriber of Group is primary.

2. If Member has coverage under both a managed care plan and an indemnity plan, the managed care plan is primary.

3. In the case of covered Dependents who are not directly covered under a Group plan, the plan of the parent whose birthday occurs earliest in the year (not the one who is oldest) is primary.

4. If two or more plans cover a person as a dependent child of separated or divorced parents, the plan of the parent with custody of the child is primary. Then, the plan of the spouse or domestic partner of the parent with custody, and finally, the plan of the parent not having custody.

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

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

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

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

ARTICLE X
MEMBER APPEALS PROCESS

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

Definition: A "complaint" or "grievance" is defined by the Plan as well as under California law as a written or oral expression of dissatisfaction regarding the Plan and/or Plan Provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative. In cases where the Plan is unable to distinguish between a "complaint" and an "inquiry," it shall be considered a complaint. Complaints must be submitted within one hundred eighty (180) calendar days of the incident or action that is the subject of Member's dissatisfaction.

A. Verbal Complaints:

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

B. Written Complaints:

Member may complete a complaint form or other similar correspondence describing his or her dissatisfaction with service or care delivered by Plan or Plan Dentist. Plan will acknowledge the written complaint within five (5) business days by notifying the complainant in writing. Plan will investigate the complaint and will provide a written resolution to Member within (30) calendar days. In matters of quality of care or clinical issues, an appropriate health professional will be consulted.

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

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

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

> The California Department of Managed Health Care is responsible for regulating health care services plans. If you have a grievance against your health plan, you should first telephone the health plan at **800.443.2995** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1.888.HMO.2219**) and a TDD line (**1.877.688.9891**) for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

ARTICLE XI
TERMINATION OF BENEFITS

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

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

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

B. If Member ceases to meet the eligibility requirements of Group, coverage will terminate on the next Prepayment Fee due date.

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

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

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

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

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

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

I. Once a Member is no longer qualified as a Dependent, coverage for that Member will terminate. Coverage shall not terminate while a Dependent child of a Subscriber is and continues to be incapable of self-sustaining employment by reason of a physical or mental disability, injury, illness or condition. Such a Dependent must be chiefly dependent on the Subscriber for maintenance and support, and the Subscriber must furnish proof of incapacity and dependency to Plan within sixty (60) days of the child attaining the limiting age. The proof of incapacity and dependency must be furnished to Plan every two years thereafter, if requested by Plan Notification will be provided to Subscribers as a reminder that they have the option to continue coverage for dependents who have a physical or mental disability, injury, illness or condition.

J. If Member no longer works or lives in Service Area.

A Member who believes his or his dependent's enrollment has been canceled or not renewed because of health status may request a review of cancellation by the Department of Managed Health Care. The Department of Managed Health Care's telephone number is **800.HMO.2219**.

ARTICLE XII
CONTINUATION OF COVERAGE/COBRA/CAL-COBRA

12.1 **Continuation of Coverage Under the Plan:** If this Agreement is terminated, each Plan Provider shall complete all dental services started prior to the date of termination. This is pursuant to the terms of an agreement between Plan and Plan Provider and as required by state law. Should a Member in orthodontia treatment terminate for any reason, each Plan Provider shall complete all orthodontia services started prior to the effective date of termination so long as the Member 1) continues to pay any required Copayments and 2) continues to receive care from the same Plan Provider who planned and initiated orthodontia treatment for the Member. If Member discontinues treatment by missing scheduled appointments or fails to abide by the Plan Provider's prescribed treatment plan, the Plan will terminate the continuation of coverage for the Member's orthodontic care.

12.2 **Continuation of Coverage Under Federal COBRA:** This section applies only if Group is an employer required to offer Federal COBRA. Under the provisions of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99-272 (COBRA), Member is granted the right to continue coverage beyond the date Member's coverage would otherwise terminate. Coverage under the Agreement shall continue until terminated by the applicable provisions of Federal law. Member should contact Group concerning eligibility.

12.3 **Continuation of Coverage Under Cal-COBRA:** This section applies only if Group is an employer required to offer Cal-COBRA. Under the provisions of California Health and Safety Code, Section 1366.20, Members who are Qualified Beneficiaries may qualify for coverage under the California Continuation Benefit Replacement Act (Cal-COBRA). Cal-COBRA also extends the continuation coverage period for eligible COBRA beneficiaries to 36 months.

Cal-COBRA Definitions: *Qualified Beneficiary*–a Member covered under the Plan on the day before a *Qualifying Event* including the spouse or domestic partner or dependent child(ren) of a Subscriber, or a child born to or placed for adoption with a Subscriber during the Cal-COBRA continuation period and who is enrolled in the Plan as a dependent within 30 days of the child's birth or placement for adoption. *Qualifying Event*–any of the following events, which would result in a loss of coverage under the Plan: 1) Termination of employment of Subscriber (for any reason other than gross misconduct) or reduction in hours of employment of Subscriber below the minimum required for coverage; 2) The death of the Subscriber; 3) Divorce or legal separation of the Subscriber and his or her spouse; 4) the Subscriber's entitlement to Medicare; or 5) the loss of dependent child status.

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

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

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

continuation coverage from the new group plan with which Subscriber's employer contracts, if employer contracts with a new group plan.)

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

ARTICLE XIII
RENEWAL PROVISION

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

ARTICLE XIV
REQUIRED NOTICES

14.1 **Public Policy Participation:** Plan seeks applicants who would be interested in participating in a committee (the Public Policy Committee) for the purposes of establishing the public policy of Plan. The committee consists of three Plan members, Plan's dental director and Plan's administrator. Members shall serve a one-year term while Plan's administrator and dental director will be permanent Members. Plan will reimburse Members $50 per meeting for their participation.

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

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

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

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

14.3 **Organ and Tissue Donation and Procedures:** Advancements in organ transplant technology allow more patients to benefit from organ transplants, but the supply of organs has not kept pace with the number of patients eligible for transplantation. The number of organs transplanted from deceased individuals increased from 10,964 in 1988 to 16,802 in 1996. But there are more than 54,000 individuals remaining on the waiting list. Organ donation is not limited by age. While two-thirds of the donors were between ages 18 through 49 in 1988, by 1996 only half were in this age group. The proportion of donors aged 50 and older doubled from about 12 percent in 1988 to about 26 percent in 1996. Each deceased donor contributes an average of three organs. Organ donation begins at the hospital when a patient is identified as a potential organ donor. Only those patients pronounced brain dead are considered for organ donation, though some organs are recovered from donors declared dead by traditional cardiac death criteria. Once a potential organ donor has been identified, a staff member of the hospital or the organ procurement organization will contact the individual's family, which has the opportunity to donate organs. If the family consents, the organ procurement organization coordinates the organ procurement activities, including preserving the organs and arranging for the transportation of the organs to the hospital where the transplant will be performed. For more information or a free donor card, you may call the Organ and Tissue Acquisition Center at 619.292.8750.

ARTICLE XV
GENERAL PROVISIONS

15.1 **Amendments:** By mutual consent, Plan and Group may modify, amend or alter Agreement. Except as otherwise agreed, such change shall be in writing and duly executed by both parties. Any change shall be attached to Agreement. Plan may amend Agreement unilaterally to comply with applicable law.

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

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

15.4 **Major Disaster or Epidemic:** In the event of any major disaster or epidemic, Provider shall render dental services insofar as practical according to his or her best judgement, within the

limitations of such facilities and personnel as are then available. Neither Plan nor Provider shall have any liability or obligation for delay or failure to provide dental services due to lack of available facilities or personnel if it occurred as a result of such disaster or epidemic.

IF YOU WOULD LIKE A COPY OF UDC'S DISCLOSURE INFORMATION, GUIDELINES, OR CRITERIA USED TO AUTHORIZE, DENY, OR MODIFY DENTAL SERVICES, PLEASE CONTACT US AT 800.443.2995.

TO CONTACT CUSTOMER SERVICE, CALL 800.443.2995

DEPENDENT AGE 26
AMENDMENT

The Combined Evidence of Coverage and Disclosure Form is amended to change the definition of Dependent as follows:

Dependent: Shall mean the spouse or domestic partner (as defined in Section 297 of the California Family Code) of any Subscriber and all newborn infants from and after the moment of birth, natural children, adopted children from the date of placement, stepchildren or the domestic partner's children, foster children and children whom the Subscriber is required to provide coverage pursuant to a court or administrative order. All such children shall be under age twenty-six (26). Dependent shall be eligible for coverage on the day Subscriber is eligible for coverage or when he or she attains the status of a dependent, whichever is later.

Dependent shall also mean the child of Subscriber twenty-six (26) or over not capable of self-sustaining employment by reason of a physically or intellectually disabling injury, illness or condition and chiefly dependent on Subscriber for maintenance and support.

This Amendment is subject to all terms, conditions and provisions of the Agreement which are not inconsistent with this Amendment.

The change in the Agreement described in this Amendment shall be effective July 1, 2019.

COMPANY: UDC Dental California, Inc.

By: _____
Signature

Frederick R. Cook, President

May 31, 2019
Date

UDC Dental California, Inc.
2175 North California Boulevard
Suite 990
Walnut Creek, CA 94596

(800-443-2995)

PLUS COPAYMENT SCHEDULE

Benefits provided by: UDC Dental California, Inc.
2175 North California Boulevard
Suite 990
Walnut Creek, CA 94596

(800-443-2995)

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

This Copayment Schedule provides a complete list of dental services covered under the Plan. These dental services are covered only when provided by Member's selected Plan Dentist. Dental services that do not appear on this list are not covered by this Plan. Member will be responsible for paying the amount listed in the "Member Copayment" column at the time the service is received or in accordance with selected Plan Dentist's billing procedures. To fully understand the benefits, exclusions and limitations of this plan, Member should consult the Combined Evidence of Coverage and Disclosure Form to determine specific dental coverage.

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

ADA Code**	Service Description**	Member Copayment
	Appointments	
None	Routine Office Visit***	5.00
D0120	Periodic oral evaluation - established patient	No Charge
D0140	Limited oral evaluation - problem focused	No Charge
D0150	Comprehensive oral evaluation - new or established patient	No Charge
D0180	Comprehensive periodontal evaluation - new or established patient	No Charge
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Charge
D9440	Office visit - after regularly scheduled hours	20.00
	Diagnostic Dentistry	
D0210	Intraoral-complete series of radiographic images	No Charge
D0220	Intraoral-periapical first radiographic image	No Charge
D0230	Intraoral-periapical each additional radiographic image	No Charge
D0240	Intraoral-occlusal radiographic image	No Charge
D0250	Extraoral-2D projection radiographic image created using a stationary radiation source, and detector	No Charge
D0260	Extraoral-each additional radiographic image	No Charge

	Diagnostic Dentistry	
D0270	Bitewing-single radiographic image	No Charge
D0272	Bitewing-two radiographic images	No Charge
D0274	Bitewing-four radiographic images	No Charge
D0330	Panoramic radiographic image	No Charge
D0415	Collection of microorganisms for culture and sensitivity	No Charge
D0425	Caries susceptibility tests	No Charge
D0460	Pulp vitality tests	No Charge
D0470	Diagnostic casts	No Charge
None	Periodontal probing in the presence of periodontal disease***	10.00
	Preventive Dentistry	
D1110	Prophylaxis - adult (once every 6 months)	No Charge
D1120	Prophylaxis - child (once every 6 months)	No Charge
D1203	Topical application of fluoride (prophylaxis not included) - child	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth	10.00
D1510	Space maintainer - fixed - unilateral	70.00
D1515	Space maintainer - fixed - bilateral	70.00
D1520	Space maintainer - removable - unilateral	80.00
D1525	Space maintainer - removable - bilateral	80.00
D1550	Re-cement or re-bond space maintainer	No Charge
	Restorative Dentistry	
D2140	Amalgam - one surface, primary or permanent****	No Charge
D2150	Amalgam - two surfaces, primary or permanent****	No Charge
D2160	Amalgam - three surfaces, primary or permanent****	No Charge
D2161	Amalgam - four or more surfaces, primary or permanent****	No Charge
D2330	Resin-based composite - one surface, anterior****	No Charge
D2331	Resin-based composite - two surfaces, anterior****	No Charge
D2332	Resin-based composite - three surfaces, anterior****	No Charge
D2391	Resin-based composite - one surface, posterior	45.00
D2392	Resin-based composite - two surfaces, posterior	55.00
D2393	Resin-based composite - three surfaces, posterior	65.00
D2740	Crown - porcelain/ceramic	185.00
D2750	Crown - porcelain fused to high noble metal*	195.00
D2751	Crown - porcelain fused to predominantly base metal	195.00
D2752	Crown - porcelain fused to noble metal*	195.00
D2790	Crown - full cast high noble metal*	95.00
D2791	Crown - full cast predominantly base metal	95.00
D2792	Crown - full cast noble metal	95.00
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration	5.00
D2920	Re-cement or re-bond crown	5.00
D2930	Prefabricated stainless steel crown - primary tooth	25.00
D2940	Protective restoration	No Charge
D2950	Core buildup, including any pins	25.00
D2951	Pin retention - per tooth, in addition to restoration	5.00
D2952	Cast post and core in addition to crown****	35.00
D2954	Prefabricated post and core in addition to crown****	50.00
D2960	Labial veneer (resin laminate) - chairside	100.00
D2980	Crown repair necessitated by restorative material failure	25.00
None	Temporary filling***	No Charge
	Endodontics	
D3110	Pulp cap - direct (excluding final restoration)	No Charge
D3120	Pulp cap - indirect (excluding final restoration)	No Charge
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	10.00
D3310	Anterior (excluding final restoration)	95.00
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	130.00
D3330	Molar (excluding final restoration)	165.00

	Endodontics	
D3346	Retreatment of previous root canal therapy - anterior	95.00
D3347	Retreatment of previous root canal therapy - premolar	130.00
D3348	Retreatment of previous root canal therapy - molar	165.00
D3410	Apicoectomy-Anterior	125.00
D3421	Apicoectomy-Premolar (first root)	160.00
D3425	Apicoectomy-Molar (first root)	180.00
D3426	Apicoectomy-Each additional root	75.00
D3430	Retrograde filling - per root	50.00
D3450	Root amputation - per root	75.00
D3920	Hemisection (including any root removal), not including root canal therapy	100.00
	Periodontics	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	100.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	60.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	250.00
D4261	Osseous surgery (including elevation of full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	155.00
D4320	Provisional splinting - intracoronal	60.00
D4321	Provisional splinting - extracoronal	50.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	40.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	25.00
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	35.00
D4910	Periodontal maintenance	25.00
None	Periodontal hygiene instructions***	No Charge
	Prosthodontics, removable	
D5110	Complete denture - maxillary	125.00
D5120	Complete denture - mandibular	125.00
D5130	Immediate denture - maxillary	140.00
D5140	Immediate denture - mandibular	140.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	135.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	135.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	150.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	150.00
D5410	Adjust complete denture - maxillary	10.00
D5411	Adjust complete denture - mandibular	10.00
D5421	Adjust partial denture - maxillary	10.00
D5422	Adjust partial denture - mandibular	10.00
D5510	Repair broken complete denture base	30.00
D5610	Repair resin denture base	30.00
D5620	Repair cast framework	30.00
D5630	Repair or replace broken clasp - per tooth	30.00
D5640	Replace broken teeth - per tooth	30.00
D5650	Add tooth to existing partial denture	30.00
D5730	Reline complete maxillary denture (chairside)	40.00
D5731	Reline complete mandibular denture (chairside)	40.00
D5740	Reline maxillary partial denture (chairside)	40.00
D5741	Reline mandibular partial denture (chairside)	40.00
D5750	Reline complete maxillary denture (laboratory)	65.00
D5751	Reline complete mandibular denture (laboratory)	65.00
D5760	Reline maxillary partial denture (laboratory)	65.00
D5761	Reline mandibular partial denture (laboratory)	65.00
D5850	Tissue conditioning, maxillary	10.00
D5851	Tissue conditioning, mandibular	10.00

	Prosthodontics, fixed	
D6210	Pontic - cast high noble metal*	115.00
D6211	Pontic - cast predominantly base metal	115.00
D6212	Pontic - cast noble metal*	115.00
D6240	Pontic - porcelain fused to high noble metal*	210.00
D6241	Pontic - porcelain fused to predominantly base metal	210.00
D6242	Pontic - porcelain fused to noble metal*	210.00
D6721	Retainer crown - resin with predominantly base metal	90.00
D6750	Retainer crown - porcelain fused to high noble metal*	210.00
D6751	Retainer crown - porcelain fused to predominantly base metal	210.00
D6752	Retainer crown - porcelain fused to noble metal*	210.00
D6790	Retainer crown - full cast high noble metal*	115.00
D6791	Retainer crown - full cast predominantly base metal	115.00
D6792	Retainer crown - full cast noble metal*	115.00
D6930	Re-cement or re-bond fixed partial denture	10.00
D6940	Stress breaker	90.00
D6980	Fixed partial denture repair, by report	40.00
	Oral Surgery	
D7111	Extraction, coronal remnants - primary tooth	17.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	17.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	30.00
D7220	Removal of impacted tooth - soft tissue	60.00
D7230	Removal of impacted tooth - partially bony	70.00
D7240	Removal of impacted tooth - completely bony	100.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	120.00
D7250	Removal of residual tooth roots (cutting procedure)	30.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	100.00
D7280	Exposure of an erupted tooth	150.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	35.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	70.00
D7471	Removal of lateral exostosis (maxilla or mandible)	95.00
D7510	Incision and drainage of abscess - intraoral soft tissue	30.00
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	70.00
	Other Services	
D9215	Local anesthesia	No Charge
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	15.00
D9241	Intravenous moderate (conscious) sedation/analgesia - first 30 minutes	120.00
D9940	Occlusal guard, by report	100.00
D9972	External bleaching-per arch-performed in office	175.00
None	External bleaching, both arches***	300.00
	Orthodontics	
None	Diagnostic Workup with Radiographs/Model***	175.00
D8030	Limited orthodontic treatment of the adolescent dentition	900.00
D8040	Limited orthodontic treatment of the adult dentition	1000.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	1695.00
D8090	Comprehensive orthodontic treatment of the adult dentition	1895.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	35.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	95.00
None	Adjusting retainer, by report***	No Charge
None	Elastics, by report***	No Charge
None	Final Orthodontics records, by report***	125.00
None	Reattached brackets and bands (limited 3 times)***	7.00
None	Replace broken ligature wires (limit 3 times)***	5.00
None	Premium Transparent brackets, per arch***	200.00

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

I. Limited Orthodontic Treatment of Primary, Transitional (mixed primary and permanent), Adolescent, or Adult Dentition. This is treatment that does not involve all the existing teeth in both upper and/or lower arches. This limited treatment is a one-time treatment in an arch to correct crowding, close an open space between teeth, or upright a malposed tooth. Limited orthodontic treatment for primary, transitional, adolescent and adult teeth is limited to 18 consecutive months of continuous treatment.

II. Orthodontic Treatment of Adolescent/Adult Dentition. This is treatment that consists of diagnosis by oral exam, radiographs and study casts (models of teeth/arches) followed by banding and /or bracketing of teeth for active treatment and correction of class I and class II jaw relationships. Comprehensive treatment is followed by a 12-month retention treatment or stage involving construction, placement of retainers and follow-up exams of retained teeth. The comprehensive phase of treatment is limited to 24 consecutive months of continuous treatment. Members are eligible for this treatment once per lifetime.

Retention treatment is limited to12 consecutive months.

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

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

ADA Code**	Service Description**	Member Copayment
	Appointments	
D0140	Limited oral evaluation - problem focused	No Charge
D0150	Comprehensive oral evaluation - new or established patient	No Charge
D0180	Comprehensive periodontal evaluation - new or established patient	No Charge
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Charge
	Diagnostic Dentistry	
D0210	Intraoral-complete series of radiographic images	25.00
D0220	Intraoral-periapical first radiographic image	No Charge
D0230	Intraoral-periapical each additional radiographic image	No Charge
D0240	Intraoral-occlusal radiographic image	No Charge
D0250	Extraoral-2D projection radiographic image created using a stationary radiation source, and detector	No Charge
D0260	Extraoral-each additional radiographic image	No Charge
D0330	Panoramic radiographic image	25.00
D0415	Collection of microorganisms for culture and sensitivity	No Charge
D0425	Caries susceptibility tests	No Charge
D0460	Pulp vitality tests	No Charge
D0470	Diagnostic casts	No Charge
None	Periodontal probing in the presence of periodontal disease***	10.00
	Preventive Dentistry	
D1110	Prophylaxis - adult (once every 6 months)	No Charge
D1120	Prophylaxis - child (once every 6 months)	No Charge

ADA Code**	Service Description**	Member Copayment
D1203	Topical application of fluoride (prophylaxis not included) - child	No Charge
D1351	Sealant - per tooth	10.00
D1510	Space maintainer - fixed - unilateral	70.00
D1515	Space maintainer - fixed - bilateral	70.00
D1520	Space maintainer - removable - unilateral	80.00
D1525	Space maintainer - removable - bilateral	80.00
D1550	Re-cement or re-bond space maintainer	No Charge
	Restorative Dentistry	
D2140	Amalgam - one surface, primary or permanent****	No Charge
D2150	Amalgam - two surfaces, primary or permanent****	No Charge
D2160	Amalgam - three surfaces, primary or permanent****	No Charge
D2161	Amalgam - four or more surfaces, primary or permanent****	No Charge
D2330	Resin-based composite - one surface, anterior****	No Charge
D2331	Resin-based composite - two surfaces, anterior****	No Charge
D2332	Resin-based composite - three surfaces, anterior****	No Charge
D2930	Prefabricated stainless steel crown - primary tooth	25.00
D2940	Protective restoration	No Charge
	Endodontics	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	10.00
D3310	Anterior (excluding final restoration)	95.00
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	130.00
D3330	Molar (excluding final restoration)	165.00
D3346	Retreatment of previous root canal therapy - anterior	95.00
D3347	Retreatment of previous root canal therapy - premolar	130.00
D3348	Retreatment of previous root canal therapy - molar	165.00
D3410	Apicoectomy-Anterior	125.00
D3421	Apicoectomy-Premolar (first root)	160.00
D3425	Apicoectomy-Molar (first root)	180.00
D3426	Apicoectomy-Each additional root	75.00
D3430	Retrograde filling - per root	50.00
D3450	Root amputation - per root	75.00
D3920	Hemisection (including any root removal), not including root canal therapy	100.00
	Periodontics	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	100.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	60.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	250.00
D4261	Osseous surgery (including elevation of full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	155.00
D4320	Provisional splinting - intracoronal	60.00
D4321	Provisional splinting - extracoronal	50.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	40.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	25.00
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	35.00
D4910	Periodontal maintenance	25.00
None	Periodontal hygiene instructions***	No Charge
	Prosthodontics, removable	
D5850	Tissue conditioning, maxillary	10.00
D5851	Tissue conditioning, mandibular	10.00
	Prosthodontics, fixed	
	Oral Surgery	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including	

ADA Code**	Service Description**	Member Copayment
	elevation of mucoperiosteal flap if indicated	30.00
D7220	Removal of impacted tooth - soft tissue	60.00
D7230	Removal of impacted tooth - partially bony	70.00
D7240	Removal of impacted tooth - completely bony	100.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	120.00
D7250	Removal of residual tooth roots (cutting procedure)	30.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	100.00
D7280	Exposure of an erupted tooth	150.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	35.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	70.00
D7471	Removal of lateral exostosis (maxilla or mandible)	95.00
D7510	Incision and drainage of abscess - intraoral soft tissue	30.00
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	70.00
	Other Services	
D9215	Local anesthesia	No Charge
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	15.00
D9241	Intravenous moderate (conscious) sedation/analgesia - first 30 minutes	120.00
	Orthodontics	
None	Diagnostic Workup with Radiographs/Model***	175.00
D8030	Limited orthodontic treatment of the adolescent dentition	900.00
D8040	Limited orthodontic treatment of the adult dentition	1000.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	1695.00
D8090	Comprehensive orthodontic treatment of the adult dentition	1895.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	35.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	95.00
None	Adjusting retainer, by report***	No Charge
None	Elastics, by report***	No Charge
None	Final Orthodontics records, by report***	125.00
None	Reattached brackets and bands (limited 3 times)***	7.00
None	Replace broken ligature wires (limit 3 times)***	5.00
None	Premium Transparent brackets, per arch***	200.00

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

I. Limited Orthodontic Treatment of Primary, Transitional (mixed primary and permanent), Adolescent, or Adult Dentition. This is treatment that does not involve all the existing teeth in both upper and/or lower arches. This limited treatment is a one-time treatment in an arch to correct crowding, close an open space between teeth, or upright a malposed tooth. Limited orthodontic treatment for primary, transitional, adolescent and adult teeth is limited to 18 consecutive months of continuous treatment.

II. Orthodontic Treatment of Adolescent/Adult Dentition. This is treatment that consists of diagnosis by oral exam, radiographs and study casts (models of teeth/arches) followed by banding and /or bracketing of teeth for active treatment and correction of class I and class II jaw relationships. Comprehensive treatment is followed by a 12-month retention treatment or stage involving construction, placement of retainers and follow-up exams of retained teeth. The comprehensive phase of treatment is limited to 24 consecutive months of continuous treatment. Members are eligible for this treatment once per lifetime. Retention treatment is limited to12 consecutive months.

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

***Sevice does not have an American Dental Association Current Dental Terminology code or descriptor.
****Restorations and endodontic posts and cores placed after root canal therapy are subject to a separate Copayment.

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

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

SUN LIFE FINANCIAL

NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out payment and health care operations, and for other purposes that are permitted or required by law. It also sets out our legal obligations concerning your protected health information. Additionally, this Notice describes your rights to access and control your protected health information.

This Notice applies only to certain health-related products provided by Sun Life Assurance Company of Canada, Sun Life and Health Insurance Company (U.S.), and the prepaid dental companies*. "Health-related products" are individual or group products that provide, or pay the cost of, medical care. These include medical, dental, vision, and long-term care products that have a health care reimbursement component. It does not apply to certain products (such as a life insurance or disability insurance policy) that may involve some use or disclosure of health information, but for which the primary function is not the reimbursement of the costs of medical care.

Protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

For questions or additional information about the Notice or the policies and procedures described in the Notice, please contact: SLF US Compliance Department, Sun Life Financial, One Sun Life Executive Park, Wellesley Hills, MA 02481, Attention: HIPAA Privacy Officer.

Effective Date

This notice becomes effective on August 31, 2013.

Our Responsibilities

We are required by law to maintain the privacy of your protected health information. We are obligated to provide you with a copy of this Notice of our legal duties and our privacy practices with respect to protected health information, and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all protected health information that we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for you.

Primary Uses and Disclosures of Protected Health Information

The following is a description of how we are most likely to use and/or disclose your protected health information. Where state law provides additional restrictions on how we can use and disclose information, we will follow applicable state laws.

Payment and Health Care Operations

We have the right to use and disclose your protected health information for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of what is known as "the HIPAA Privacy Regulations"). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

- Payment
  We will use or disclose your protected health information to obtain premiums, to determine cost share, or otherwise fulfill our responsibilities for coverage and providing benefits as established under your health care plan or member contract. For example, we may disclose your protected health information when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

- Health Care Operations
  We will use or disclose your protected health information to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, business planning, and business development. For example, we may use your information (i) to provide you with information about one of our disease management programs or about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan, (ii) to respond to a customer service inquiry from you, (iii) to review the quality of medical services being provided to you, or (iv) to conduct audits or medical review of claims activity. We may also use or disclose protected health information for underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations (although we are prohibited from using or disclosing any genetic information for these underwriting purposes).

Business Associates

We contract with individuals and entities (known as "business associates") to perform various functions on our behalf or to provide certain types of services. Some of the functions they provide are administering claims, member service support, utilization management, subrogation, and pharmacy benefit management. To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

Plan Sponsor
We may disclose your protected health information to the plan sponsor of your group health plan.

Other Possible Uses and Disclosures of Protected Health Information

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your protected health information.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits; investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system, (ii) government benefit programs, (iii) other government regulatory programs, and (iv) compliance with civil rights laws.

Required by Law
We may use or disclose your protected health information to the extent that federal, state, or local law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Regulations.

Public Health Activities
We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose protected health information, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

Abuse or Neglect
We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your information if we believe that you have been a victim of abuse, neglect, or domestic violence.

Legal Proceedings
We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Regulations.

Law Enforcement
Under certain conditions, we also may disclose your protected health information to law enforcement officials. Some of the reasons for such a disclosure may include, but are not limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (3) it is necessary to provide evidence of a crime that occurred on our premises.

Coroners, Medical Examiners, Funeral Directors, and Organ Donation
We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

Research
We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information and (2) approved the research.

To Prevent a Serious Threat to Health or Safety
Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security, Protective Services
Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

Inmates
If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

Workers' Compensation

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Others Involved in Your Health Care

Unless you object, we may disclose your protected health information to a friend or family member that you have identified as being involved in your health care. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make.

Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Regulations.

Disclosures to You

We are required to disclose to you most of your protected health information in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of many disclosures of your protected health information that are for reasons other than payment and health care operations.

Other Uses and Disclosures of Your Protected Health Information

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. To the extent (if any) that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. Also, to the extent (if any) that we use or disclose your information for our fundraising practices, we will provide you with the ability to opt out of future fundraising communications. In addition, most (but not all) uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of protected health information, require your authorization. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be

effective for information that we already have used or disclosed in reliance on your authorization.

Your Rights

The following is a description of your rights with respect to your protected health information.

Right to Request a Restriction
You have the right to request a restriction on the protected health information we use or disclose about you for payment or health care operations.

We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

You may request a restriction by writing. In your request tell us: (1) the information for which you wish to limit disclosure and (2) how you want to limit our use and/or disclosure of the information.

Right to Request Confidential Communications
If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you can ask that we only contact you at your work address or via your work e-mail.

You may request a restriction by writing. In your request tell us: (1) the parts of your protected health information that you want us to communicate with you in an alternative manner or at an alternative location and (2) that the disclosure of all or part of the information in a manner inconsistent with your instructions would put you in danger.

Right to Inspect and Copy
You have the right to inspect and copy your protected health information that is contained in a "designated record set." This may include an electronic copy in certain circumstances if you make this request in writing. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your protected health information that is contained in a designated record set, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional

chosen by us will review your request and the denial. The person performing this review will not be the same person who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

Right to Amend

If you believe that your protected health information is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by writing and should include the reason the amendment is necessary.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

Right of an Accounting

You have a right to an accounting of most disclosures of your protected health information that are for reasons other than payment or health care operations. An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

Right to a Paper Copy of This Notice

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

To fulfill any of the above requests in writing, send the description of your request to: *SLF US Compliance Department, Sun Life Financial, One Sun Life Executive Park, Wellesley Hills, MA 02481, Attention: HIPAA Privacy Officer.*

Breach Notification: In the event of a breach of your unsecured health information, we will provide you notification of such a breach as required by law or where we otherwise deem appropriate.

Complaints

If you believe that we have violated your privacy rights, you may file a complaint with us by writing to: *SLF US Compliance Department, Sun Life Financial, One Sun Life Executive Park, Wellesley Hills, MA 02481, Attention: HIPAA Privacy Officer*

You may also submit a complaint to the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

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

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