United Dental Care of Arizona, Inc.
Executive Office:
One Sun Life Executive Park
Wellesley Hills, MA 02481

(800-443-2995)

EVIDENCE OF COVERAGE

ARTICLE I
DEFINITIONS

1.1 **Agreement:** The Group Dental Service Agreement between Group and Company and related documents constituting the entire contract under which Plan Benefits are provided to Members.

1.2 **Anniversary Date:** Agreement's first Anniversary Date is the day after the initial Plan Year ends, as stated in Agreement. The Anniversary Date occurs on the same date in each subsequent year, as stated in Agreement.

1.3 **Company:** United Dental Care of Arizona, Inc.

1.4 **Copayment:** Shall mean a per-service fee charged to Member by Plan Provider as identified in the Copayment Schedule.

1.5 **Dental Emergency:** The sudden and unexpected onset of an acute condition involving severe pain, requiring immediate dental care for temporary pain relief.

1.6 **Dependent:** Subscriber's spouse and Subscriber's natural children from and after moment of birth, adopted children from date of placement, stepchildren and foster children. To be eligible, all such children must be under age nineteen (19) years (the "Limiting Age") and unmarried. To be eligible, stepchildren and foster children must also be chiefly dependent on Subscriber for maintenance and support. Eligibility may be extended past the Limiting Age for unmarried children under age twenty-five (25) years who are registered students in regular, full-time attendance at an accredited school, college or university and are chiefly dependent on Subscriber for maintenance and support. Eligibility may be extended past the Limiting Age for unmarried children who are not capable of self-sustaining employment due to a disability or physical handicap and are chiefly dependent on Subscriber for maintenance and support. If Company requests proof of a Dependent's eligibility, Subscriber must furnish proof within 31 days of Company's request. Company will not require proof of a Dependent's continuing eligibility more than once a year.

1.7 **Effective Date:** The date Agreement becomes effective, as stated in Agreement.

1.8 **Emergency Services:** Those dental services required for temporary pain relief in a Dental Emergency.

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

1.10 **Member:** Shall mean a Subscriber or Dependent enrolled in Plan.

1.11 **Non-Plan Dentist:** A general dentist who is not a Plan Dentist.

1.12 **Non-Plan Provider:** A Non-Plan Dentist or a Non-Plan Specialist, or a hygienist or technician acting with or assisting such a dentist.

1.13 **Non-Plan Specialist:** A dentist practicing in a dental specialty who is not a Plan Specialist.

1.14 **Plan Benefits:** Shall mean benefits for services provided under Agreement, subject to any limitations and exclusions.

1.15 **Plan Dentist:** Shall mean a licensed General Dentist who, at time Plan Benefits are provided, is under contract with Company to provide certain dental services to Members. Copayments listed in the **PLAN DENTIST SERVICES** Section of the Copayment Schedule apply only to Plan Dentists who perform the corresponding services listed in the Copayment Schedule. The Plan Dentist selected by Member may not perform all listed services. In order to fully understand payment responsibility for dental services, Member should discuss availability of services and the proposed treatment and its cost with selected Plan Dentist prior to receiving treatment.

1.16 **Plan Provider:** Shall mean a Plan Dentist or Plan Specialist who, at time Plan Benefits are provided, is under contract with Company to provide services to Members. The term shall include any hygienists and technicians recognized by the dental profession who act with and assist Plan Dentist or Plan Specialist. A list of Plan Providers shall be published in Plan Dentist Directory. Company has sole discretion to determine which providers may be Plan Providers. Plan Providers are independent contractors in private practice and are neither employees nor agents of Company. Company cannot guarantee the availability of any specific provider as a Plan Provider. The status of providers as Plan Providers is subject to change.

1.17 **Plan Specialist:** Shall mean a licensed dentist practicing in a dental specialty who, at time Plan Benefits are provided, is under contract with Company to provide dental specialty services to Members. Some examples of "dentists practicing in a dental specialty" are endodontists, periodontists, oral surgeons, orthodontists and pedodontists. Each Plan Specialist will participate in only one of the following two categories:

> **Non-SBA Plan Specialist**—offers any dental specialty service he provides to Members at a specific reduction from his normal retail charge.
>
> **SBA Plan Specialist**—offers certain dental specialty services he provides to Members for specified Copayments (services and Copayments listed in the **SPECIALIST SERVICES** Section of the Copayment Schedule) and offers all other dental specialty services he provides to Members at a specific reduction from his normal retail charge.

In order to fully understand payment responsibility for dental specialty services, Member should discuss the proposed treatment and its cost with Plan Specialist prior to receiving treatment. Availability of specific types of specialty services from SBA or Non-SBA Plan Specialists depends on which types of dentists are SBA or Non-SBA Plan Specialists. Company cannot guarantee the availability of any specific type of dentist as an SBA or Non-SBA Plan Specialist. Types of dentists who are SBA or Non-SBA Plan Specialists may vary from time to time in different parts of the Service Area. Copayments listed in the **SPECIALIST SERVICES** Section of the Copayment Schedule apply only to SBA Plan Specialists who perform the corresponding services listed in the Copayment Schedule. The SBA Plan Specialist selected by Member may not perform all listed services

1.18 **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.

1.19 **Prepayment Fee:** The periodic fee paid to Company for each Member's coverage.

1.20 **Service Area:** The geographic area where Plan Benefits are available. The extent of the Service Area is within the sole discretion and determination of Company.

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

ARTICLE II
ELIGIBILITY AND MEMBER EFFECTIVE DATE

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

If an additional Prepayment Fee is required for coverage of Subscriber's newly born natural child or Subscriber's child newly placed for adoption, and if Subscriber wishes to have the child covered as of the date of birth or placement, Group must notify Company and pay the additional Prepayment Fee within thirty-one (31) days after that date.

2.2 **Coverage of Members/Effective Date:** Each Subscriber or Dependent whose Prepayment Fee has been accepted by Company on or before the 20th day of a month will be covered beginning the first day of the following month. Each Subscriber or Dependent whose Prepayment Fee has been accepted by Company after the 20th day, but by the last day, of a month will be covered beginning the first day of the second following month.

ARTICLE III
MEMBER'S COPAYMENTS

3.1 **Member's Copayments and Other Charges:** Member is responsible for payment of all Copayments, any additional laboratory fees for certain dental services as stated in the Copayment Schedule, and all charges for services that are not Plan Benefits. Member must pay dental provider at the time service is rendered. Member may have an option to pay according to provider's billing procedures.

ARTICLE IV
BENEFITS AND COVERAGES

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

4.2 **Plan Benefits:** Company shall provide benefits for dental services to Members as set forth in the Evidence of Coverage and Copayment Schedule. Services are subject to limitations and exclusions. Services are provided for the term of Agreement. Company reserves the right to change Plan Benefits after the initial Plan Year. Notice of change is subject to sixty (60) days written notice.

4.3 **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, Company reserves the right to update Agreement to reflect the most current dental terminology.

4.4 **Provision of Plan Benefits/Plan Providers:** Except as specifically provided in the **EMERGENCY SERVICES** Article of the Evidence of Coverage and the **SPECIALIST SERVICES** Section of the Copayment Schedule, Agreement provides only for services performed by a Plan Provider. Except as specifically provided in the **EMERGENCY SERVICES** Article of the Evidence

of Coverage and the **SPECIALIST SERVICES** Section of the Copayment Schedule, Company shall not have any liability due to treatment by any Non-Plan Provider. In addition, Company shall not have any liability due to treatment by any physician, hospital, other person, institution or group. Each Member shall select a Plan Dentist from the Plan Dentist Directory furnished by Group to Member. Specialty services covered by Plan may be obtained from a Plan Specialist or Non-Plan Specialist. Agreement provides for services only. It is not an insurance policy. It does not reimburse Member or Group except as specifically provided in the **EMERGENCY SERVICES** Article of the Evidence of Coverage and the **SPECIALIST SERVICES** Section of the Copayment Schedule.

4.5 **Selection of Provider:**

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

Change of Selected Plan Dentist: Member or Plan Dentist may request a change of Plan Dentist selection by contacting Company. Change requests received by the 20th day of a month will be effective on the first day of the next following month. Change requests received after the 20th day of a month will be effective the first day of the second following month. Plan Benefits will not be available for services from the newly-selected Plan Dentist until the change request is received and implemented by Company.

B. Plan Specialist: If Member requires specialist services that cannot be provided by Member's selected Plan Dentist, Member may obtain services from a Plan Specialist or a Non-Plan Specialist. No referral from Member's selected Plan Dentist is needed. Member's out-of-pocket amount may vary depending on whether services are received from an SBA Plan Specialist, a Non-SBA Plan Specialist, or a Non-Plan Specialist.

4.6 **Member/Plan Provider Relationship:** The relationship between Member and Plan Provider shall be an independent professional one. Plan Provider shall be solely responsible, without intrusion by Company or Group for all services within the professional relationship between Member and Plan Provider. Company has the right to refuse Plan Benefits, and Plan Provider has 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 make required payments (including but not limited to Copayments, laboratory fees or missed appointment fees) or any charges for non-covered procedures; (4) uses the relationship for illegal purposes; or (5) otherwise makes the professional relationship unduly burdensome.

4.7 **Providers Not Participating with Plan:** Company does not review practice standards of Non-Plan Providers. Members who obtain services from Non-Plan Providers should separately assess the practice standards and skills of those providers.

ARTICLE V
LIMITATIONS AND EXCLUSIONS

5.1 **Pre-Existing Conditions:** Agreement's exclusions and limitations apply with respect to Member's oral conditions without regard to whether or not such conditions existed before the effective date of Member's enrollment for Plan Benefits.

5.2 **Exclusions:** Plan Benefits are not available for:

A. Any services not specifically described in the Copayment Schedule (including but not limited to any hospital or outpatient care facility cost associated with any dental service).

B. Any dental service initiated (a) before the effective date of Member's enrollment for Plan Benefits or (b) after Member's enrollment for Plan Benefits ends.

C. Services provided by Non-Plan Providers unless (a) for services of Non-Plan Specialists as specifically provided in the **SPECIALIST SERVICES** Section of the Copayment Schedule or (b) for Emergency Services as specifically provided in the **EMERGENCY SERVICES** Article of the Evidence of Coverage.

D. Replacement of bridgework, dentures or other fixed or removable appliances unless (a) at least five (5) years have elapsed since such appliance was provided as a Plan Benefit, or (b) during that five (5) year period, appliance becomes unusable and cannot be made usable due to Member's illness or an accident involving damage to the appliance while it is in use.

E. Replacement of dentures or other removable appliances due to (a) damage while not in use or (b) loss or theft.

F. Oral reconstruction using fixed bridgework or other fixed appliances if the overall treatment plan to achieve complete oral reconstruction involves the replacement of six (6) or more teeth (whether those teeth are missing before treatment begins or are extracted as part of the overall treatment plan).

G. Implants or any related implant appliances, or surgery for the insertion of implants or any related implant appliances, whether fixed or removable.

H. Surgical removal of implants or implant appliances, or any surgical or non-surgical services to adjust, repair, replace, or treat any problem related to an existing implant or implant appliance, whether fixed or removable.

I. Restorations or splints used to increase vertical dimension, restore occlusion, or replace or stabilize tooth structure lost by attrition.

J. Orthodontic treatment involving therapy for myofunctional problems, TMJ (temporomandibular joint) dysfunctions, micrognathia, macroglossia, cleft palate or other growth and developmental abnormalities.

K. Orthodontic treatment associated with orthognathic surgery, whether the treatment precedes or follows the surgery.

L. Extractions of third molars (wisdom teeth) that are not symptomatic, whether or not the extractions follow the completion of orthodontic treatment. Examples of symptomatic conditions include decay, odontogenic cysts, chronic pericoronitis and infection.

M. Treatment of malignancies, neoplasms or cysts, including but not limited to biopsies.

5.3 **Orthodontic Extractions:** Extractions by a Plan Provider for solely orthodontic purposes are not subject to the fixed Copayments shown for extractions in the Copayment Schedule. Instead, such extractions are subject to charges reflecting a 25% reduction from that Plan Provider's normal retail charges for such extractions.

5.4 **Services of Non-Plan Specialists:** Plan Benefit payments for services of Non-Plan Specialists, as provided in the **SPECIALIST SERVICES** Section of the Copayment Schedule, are limited to a total of $2,000.00 per calendar year.

ARTICLE VI
EMERGENCY SERVICES

6.1 **If Selected Plan Dentist Is Available:** A Member who has a Dental Emergency should seek care from his or her selected Plan Dentist. Plan Benefits apply to all services of the Member's selected Plan Dentist as stated in the **PLAN DENTIST SERVICES** Section of the Copayment Schedule.

6.2 **If Selected Plan Dentist Is Not Available:** If a Member has a Dental Emergency and the Member's selected Plan Dentist is not available, the Member may seek and receive Emergency Services from any other licensed dentist within the United States of America. Company will reimburse expenses for Emergency Services provided by such dentist up to a maximum of fifty dollars ($50.00) per Dental Emergency, not to exceed one hundred dollars ($100.00) per Member per calendar year for all Dental Emergencies and all such dentists combined. All other charges related to emergency care will be the responsibility of the Member.

6.3 **Expense Reimbursement:** Reimbursement of expenses for Emergency Services is subject to the following conditions:

A. The only expenses eligible for reimbursement are expenses for services of a dentist (other than Member's selected Plan Dentist) within the United States of America, where the services qualify as Emergency Services as stated in the definition of "Emergency Services" in the **DEFINITIONS** Article of the Evidence of Coverage.

B. If Emergency Services are performed at a hospital or outpatient care facility other than a dentist's office, reimbursement is not available for the hospital's or facility's charges.

ARTICLE VII
DENTAL CHARGES PAID BY MEMBERS

7.1 Company does not reimburse Member except for limited benefits for Emergency Services as specifically stated in the **EMERGENCY SERVICES** Article of the Evidence of Coverage and for certain Non-Plan Specialist services as specifically stated in the **SPECIALIST SERVICES** Section of the Copayment Schedule. Reimbursement of Member expenses for such services is subject to the following conditions:

A. Proof of Expenses: Member must furnish satisfactory written proof of covered expenses to Company. This must be within sixty (60) days after receipt of the services for which Member seeks reimbursement.

B. Failure to Furnish Proof of Expenses: Failure to furnish proof to Company within the required time shall not nullify or reduce reimbursement. This is true: (1) only if it was not reasonably possible to provide proof within such time and (2) if proof is furnished as soon as reasonably possible.

C. Reimbursement of Expenses: Reimbursement requests will be processed within sixty (60) days of Company's receipt of satisfactory written proof of expenses. This applies unless Member is notified of the need for additional time. If reimbursement is denied, written notice shall be given to Member. Such notice will contain the reasons for denial.

D. Limitations of Actions: No action at law or equity shall be brought under this Article against Company prior to the end of the ninety (90) day period following the date on which satisfactory written proof of the expenses has been furnished to Company. No such action shall be brought later than three (3) years after the ending of the period of time in which such proof of expenses must be furnished to Company.

ARTICLE VIII
MEMBER APPEALS PROCESS

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

A. Verbal Complaint: Member may contact Company 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. Company 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 Company. Company Customer Service Representative will provide Member with the guidelines. In addition, such representative will provide complaint form to be completed.

B. Written Complaint: Company expects receipt of a completed complaint form or correspondence from Member expressing dissatisfaction with service or care delivered by Company or Plan Dentist. Once this occurs, Company will acknowledge the written complaint within five (5) business days. Company will investigate the complaint and will provide a written resolution to Member within thirty (30) calendar days. In matters of quality of care or clinical issues, an appropriate health professional will be consulted. If the complaint is not resolved to Member's satisfaction, Member should follow the appeal procedures as outlined in the attached Health Care Insurer Appeals Process Information.

ARTICLE IX
TERMINATION

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

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

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

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

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

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

E. If Member fails to make required payments, Company reserves the right to terminate coverage upon sixty (60) days written notice. Such payments include, but are not limited to Copayments, laboratory fees or missed appointment fees. Prepayment Fees received for terminated Member for the period after termination date shall be refunded to Group. Thereafter, Company shall have no further liability or responsibility to Member.

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

G. 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.

H. Once a Member is no longer qualified as a Dependent, coverage for that Member will terminate.

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

ARTICLE X
CONTINUATION OF COVERAGE/ COBRA

10.1 **Services in Progress at Termination:** If Member's enrollment ends for any reason, each Plan Provider is required to complete all dental services initiated prior to the date Member's enrollment ends. Member's financial responsibility for such services is determined according to the terms of Agreement in effect on the last day of Member's enrollment.

10.2 **Continuation of Coverage under COBRA:** If under the provisions of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99-272, Member is granted the right to continue coverage beyond the date Member's coverage would otherwise terminate, the following applies. Agreement shall be deemed to allow coverage to continue to comply with the provisions of applicable statutes. Member should contact Group concerning eligibility.

ARTICLE XI
GENERAL PROVISIONS

11.1 **Amendments:** Company reserves the right to modify, amend or alter Agreement. Any such change will be in writing and duly executed by Company, except to the extent Company updates Plan Benefits to be based on the most current dental terminology.

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

11.3 **Circumstances Beyond Company's Control**: Rendition of dental services may be delayed or made impractical due to circumstances not within Company's control. If this occurs, neither Company nor Plan Provider shall have any liability or obligation to provide services on account of such delay. This includes, but is not limited to, complete or partial destruction of facilities, war, riot and civil insurrection. It also includes labor disputes or disability of a significant number of Plan Providers.

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

ARTICLE XII
NON-INSURANCE DISCOUNT VISION PROGRAM

12.1 **Non-Insurance Discount Vision Program:** Each Member is eligible for a non-insurance discount vision program ("Vision Program"). Under the Vision Program, Company arranges for third party providers to furnish discounted vision services and/or goods to Members. The Vision Program offers discounts on goods and/or services. It is not insurance. Third party service providers, and not Company, are liable to Members for the provision of such goods and/or services. Company is not responsible for the provision of goods and/or services, nor is Company

liable for the failure of the provision of the same. Company is not liable to Members for the negligent provision of such goods and/or services by third party service providers. The termination date of any Member's enrollment for Plan Benefits is the termination date of that Member's eligibility for the Vision Program. The termination date of Agreement is the termination date of the Vision Program. Company reserves the right to terminate or modify the Vision Program at its sole discretion and without notice to Members (whether or not during the initial Plan Year).

TO CONTACT CUSTOMER SERVICE, CALL 800.443.2995

DEPENDENT AGE 26
AMENDMENT

The Evidence of Coverage is amended to change the definition of Dependent as follows:

Dependent: Subscriber's spouse and Subscriber's natural children from and after moment of birth, adopted children from date of placement, stepchildren and foster children. To be eligible, all such children must be under age twenty-six (26) years (the "Limiting Age"). To be eligible, stepchildren and foster children must also be chiefly dependent on Subscriber for maintenance and support. Eligibility may be extended past the Limiting Age for unmarried children who are not capable of self-sustaining employment due to a disability or physical handicap and are chiefly dependent on Subscriber for maintenance and support. If Company requests proof of a Dependent's eligibility, Subscriber must furnish proof within 31 days of Company's request. Company will not require proof of a Dependent's continuing eligibility more than once a year.

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 October 1, 2019.
COMPANY: United Dental Care of Arizona, Inc.

By: Stacia N. Almquist
_____
Signature

Stacia Almquist, President
_____
Print Name and Title

July 17, 2019
_____
Date

INDEX

United Dental Care of Arizona, Inc.
Executive Office:
One Sun Life Executive Park
Wellesley Hills, MA 02481

(800-443-2995)

PLUS PLAN WITH SPECIALTY BENEFIT COPAYMENT SCHEDULE

SECTION I: PLAN DENTIST SERVICES
(Subject to Limitations and Exclusions Listed in Evidence of Coverage)

Plan Benefits are provided for the dental services listed in this **Plan Dentist Services** Section of the Copayment Schedule only when services are provided by Member's selected Plan Dentist. Limited benefits for Emergency Services from other Plan Dentists are provided as specifically stated in the **EMERGENCY SERVICES** Article of the Evidence of Coverage. Plan Benefits are not available for dental services that do not appear on the Copayment Schedule. To fully understand the benefits, exclusions and limitations of this plan, Member should consult the Evidence of Coverage.

Member is responsible for paying the amount listed in the **Member Copayment** column, plus any additional laboratory ("lab") fees for certain dental services. Payment may be due at the time the service is received or in accordance with Plan Dentist's billing procedures. Lab fees may apply to services with an asterisk (*). For such a service, the lab fee is that Plan Dentist's normal retail lab fee for that service.

The most current dental terminology may not be reflected in the Copayment Schedule. However, Plan Benefits will be based on the most current dental terminology. Company reserves the right to update the Copayment Schedule to reflect the most current dental terminology, with at least thirty (30) days written notice to Group.

The Plan Dentist selected by Member may not perform all listed services. To fully understand payment responsibility for dental services, Member should discuss availability of services, the proposed treatment, and cost with selected Plan Dentist prior to treatment. Availability of any specific general dentist as a Plan Dentist is not guaranteed.

Payment for all services received from a Non-Plan Dentist (at the Non-Plan Dentist's entire normal retail charge) is the responsibility of Member, except for limited benefits for Emergency Services as specifically stated in the EMERGENCY SERVICES Article of the Evidence of Coverage.

ADA Code**	Service Description**	Member Copayment
	Appointments	
None	Office visit - during regularly scheduled hours***	10.00
D0120	Periodic oral evaluation - established patient (may only be obtained once in any 6 calendar months, except for medically necessary more frequent prophylaxis as determined by Member's Plan Dentist)	No Charge
D0140	Limited oral evaluation - problem focused	20.00
D0150	Comprehensive oral evaluation - new or established patient (may only be obtained once in any 6 calendar months, except for medically necessary more frequent prophylaxis as determined by Member's Plan Dentist)	No Charge

ADA Code**	Service Description**	Member Copayment
D0160	Detailed and extensive oral evaluation - problem focused, by report	15.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	15.00
D0180	Comprehensive periodontal evaluation - new or established patient	15.00
None	Missed appointment without 24 hour notice***	20.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	55.00
D9440	Office visit - after regularly scheduled hours	40.00
	Diagnostic Dentistry	
D0210	Intraoral-complete series of radiographic images (once in any 3 calendar years)	No Charge
D0220	Intraoral-periapical first radiographic image	No Charge
D0230	Intraoral-periapical each additional radiographic image	No Charge
D0240	Intraoral-occlusal radiographic image	No Charge
D0250	Extraoral-2D projection radiographic image created using a stationary radiation source, and detector	No Charge
D0260	Extraoral-each additional radiographic image	No Charge
D0270	Bitewing-single radiographic image	No Charge
D0272	Bitewing-two radiographic images (may only be obtained once in any six calendar months, except for medically necessary more frequent prophylaxis as determined by Member's Plan Dentist)	No Charge
D0274	Bitewing-four radiographic images (may only be obtained once in any six calendar months, except for medically necessary more frequent prophylaxis as determined by Member's Plan Dentist)	No Charge
D0277	Vertical bitewings-7 to 8 radiographic images	No Charge
D0330	Panoramic radiographic image (once in any 3 calendar years)	5.00
D0415	Collection of microorganisms for culture and sensitivity	No Charge
D0425	Caries susceptibility tests	No Charge
D0460	Pulp vitality tests	No Charge
	Preventive Dentistry	
D1110	Prophylaxis - adult (may only be obtained once in any six calendar months, except for medically necessary more frequent prophylaxis as determined by Member's Plan Dentist)	5.00
D1120	Prophylaxis - child (may only be obtained once in any six calendar months, except for medically necessary more frequent prophylaxis as determined by Member's Plan Dentist)	5.00
D1203	Topical application of fluoride - child	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth	15.00
D1510	Space maintainer - fixed - unilateral*	70.00
D1515	Space maintainer - fixed - bilateral*	70.00
D1520	Space maintainer - removable - unilateral*	90.00
D1525	Space maintainer - removable - bilateral*	105.00
D1550	Re-cement or re-bond space maintainer	15.00
None	Additional prophylaxis (D1110 or D1120 service does not apply to patients with periodontal disease)***	30.00
	Restorative Dentistry	
D2140	Amalgam - one surface, primary or permanent	20.00
D2150	Amalgam - two surfaces, primary or permanent	25.00
D2160	Amalgam - three surfaces, primary or permanent	35.00
D2161	Amalgam - four or more surfaces, primary or permanent	45.00
D2330	Resin-based composite - one surface, anterior	35.00
D2331	Resin-based composite - two surfaces, anterior	45.00
D2332	Resin-based composite - three surfaces, anterior	55.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	70.00
D2391	Resin-based composite - one surface, posterior	75.00
D2392	Resin-based composite - two surfaces, posterior	80.00
D2393	Resin-based composite - three surfaces, posterior	95.00
D2394	Resin-based composite - four or more surfaces, posterior	110.00
D2510	Inlay - metallic - one surface*	230.00
D2520	Inlay - metallic - two surfaces*	255.00

ADA Code**	Service Description**	Member Copayment
D2530	Inlay - metallic - three or more surfaces*	285.00
D2542	Onlay - metallic - two surfaces*	280.00
D2543	Onlay - metallic - three surfaces*	295.00
D2544	Onlay - metallic - four or more surfaces*	320.00
D2610	Inlay - porcelain/ceramic one surface*	265.00
D2620	Inlay - porcelain/ceramic two surfaces*	285.00
D2630	Inlay - porcelain/ceramic three or more surfaces*	305.00
D2740	Crown - porcelain/ceramic*	265.00
D2750	Crown - porcelain fused to high noble metal*	265.00
D2751	Crown - porcelain fused to predominantly base metal*	265.00
D2752	Crown - porcelain fused to noble metal*	265.00
D2790	Crown - full cast high noble metal*	265.00
D2791	Crown - full cast predominantly base metal*	265.00
D2792	Crown - full cast noble metal*	265.00
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration	20.00
D2920	Re-cement or re-bond crown	20.00
D2930	Prefabricated stainless steel crown - primary tooth	80.00
D2940	Protective restoration	25.00
D2950	Core buildup, including any pins	50.00
D2951	Pin retention - per tooth, in addition to restoration	20.00
D2952	Post and core in addition to crown, indirectly fabricated*	110.00
D2954	Prefabricated post and core in addition to crown	80.00
D2962	Labial veneer (porcelain laminate) - laboratory*	320.00
D2980	Crown repair necessitated by restorative material failure*	25.00
None	Temporary filling***	20.00
	Endodontics	
D3110	Pulp cap - direct (excluding final restoration)	15.00
D3120	Pulp cap - indirect (excluding final restoration)	10.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	40.00
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	125.00
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	220.00
D3330	Endodontic therapy, molar (excluding final restoration)	275.00
D3346	Retreatment of previous root canal therapy - anterior	325.00
D3347	Retreatment of previous root canal therapy - premolar	385.00
D3348	Retreatment of previous root canal therapy - molar	465.00
D3410	Apicoectomy-Anterior	150.00
D3421	Apicoectomy-Premolar (first root)	180.00
D3425	Apicoectomy-Molar (first root)	220.00
D3426	Apicoectomy-Each additional root	100.00
D3430	Retrograde filling - per root	55.00
D3450	Root amputation - per root	100.00
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	150.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	65.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	140.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	100.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	350.00
D4261	Osseous surgery (including elevation of full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	203.00

ADA Code**	Service Description**	Member Copayment
D4320	Provisional splinting - intracoronal	125.00
D4321	Provisional splinting - extracoronal	95.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	65.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	39.00
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	75.00
D4910	Periodontal maintenance	45.00
None	Periodontal hygiene instructions***	No Charge
	Prosthodontics, removable	
D5110	Complete denture - maxillary*	365.00
D5120	Complete denture - mandibular*	365.00
D5130	Immediate denture - maxillary*	400.00
D5140	Immediate denture - mandibular*	400.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)*	375.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)*	375.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	465.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	465.00
D5410	Adjust complete denture - maxillary	30.00
D5411	Adjust complete denture - mandibular	30.00
D5421	Adjust partial denture - maxillary	30.00
D5422	Adjust partial denture - mandibular	30.00
D5510	Repair broken complete denture base*	40.00
D5610	Repair resin denture base*	40.00
D5620	Repair cast framework*	70.00
D5630	Repair or replace broken clasp - per tooth*	40.00
D5640	Replace broken teeth - per tooth*	40.00
D5650	Add tooth to existing partial denture*	40.00
D5730	Reline complete maxillary denture (chairside)	75.00
D5731	Reline complete mandibular denture (chairside)	75.00
D5740	Reline maxillary partial denture (chairside)	75.00
D5741	Reline mandibular partial denture (chairside)	75.00
D5750	Reline complete maxillary denture (laboratory)*	110.00
D5751	Reline complete mandibular denture (laboratory)*	110.00
D5760	Reline maxillary partial denture (laboratory)*	110.00
D5761	Reline mandibular partial denture (laboratory)*	110.00
D5850	Tissue conditioning, maxillary	50.00
D5851	Tissue conditioning, mandibular	50.00
D5862	Precision attachment, by report*	150.00
	Prosthodontics, fixed	
D6210	Pontic - cast high noble metal*	305.00
D6211	Pontic - cast predominantly base metal*	305.00
D6212	Pontic - cast noble metal*	305.00
D6240	Pontic - porcelain fused to high noble metal*	305.00
D6241	Pontic - porcelain fused to predominantly base metal*	305.00
D6242	Pontic - porcelain fused to noble metal*	305.00
D6251	Pontic - resin with predominantly base metal*	305.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis*	140.00
D6721	Retainer crown - resin with predominantly base metal*	305.00
D6750	Retainer crown - porcelain fused to high noble metal*	305.00
D6751	Retainer crown - porcelain fused to predominantly base metal*	305.00
D6752	Retainer crown - porcelain fused to noble metal*	305.00
D6780	Retainer crown - 3/4 cast high noble metal*	265.00
D6790	Retainer crown - full cast high noble metal*	265.00
D6791	Retainer crown - full cast predominantly base metal*	265.00

ADA Code**	Service Description**	Member Copayment
D6792	Retainer crown - full cast noble metal*	265.00
D6930	Re-cement or re-bond fixed partial denture	45.00
D6940	Stress breaker	150.00
D6950	Precision attachment	195.00
D6980	Fixed partial denture repair, by report*	50.00
None	Resin bonded bridge pontic, per unit***(*)	235.00
	Oral Surgery	
D7111	Extraction, coronal remnants - primary tooth	20.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	20.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	55.00
D7220	Removal of impacted tooth - soft tissue	65.00
D7230	Removal of impacted tooth - partially bony	80.00
D7240	Removal of impacted tooth - completely bony	100.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	135.00
D7250	Removal of residual tooth roots (cutting procedure)	50.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	105.00
D7280	Exposure of an erupted tooth	100.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	100.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	100.00
D7510	Incision and drainage of abscess - intraoral soft tissue	100.00
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	125.00
	Other Services	
D9220	Deep sedation/general anesthesia - first 30 minutes	185.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	15.00
D9241	Intravenous moderate (conscious) sedation/analgesia - first 30 minutes	170.00
D9242	Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes	30.00
D9940	Occlusal guard, by report*	85.00
D9951	Occlusal adjustment - limited	35.00
D9952	Occlusal adjustment - complete	170.00
	Bleaching	
D9972	External bleaching-per arch-performed in office	155.00

SECTION II: PLAN SPECIALIST SERVICES
(Subject to Limitations and Exclusions Listed in the Evidence of Coverage)

If Member requires dental specialty services that cannot be provided by selected Plan Dentist, Member may obtain such services from a SBA Plan Specialist or Non-SBA Plan Specialist. No referral from Member's selected Plan Dentist is needed. There is no applicable copayment schedule for Plan Specialist services. Instead, the following reductions in charges apply: A 15% reduction from that Plan Specialist's normal retail charges applies to services obtained from a Plan Specialist who is an endodontist. A 25% reduction from that Plan Specialist's normal retail charges applies to services obtained from any other Plan Specialist (including, but not limited to, a Plan Specialist who is an orthodontist. Member is responsible for paying the entire reduced charge either at the time the service is received or in accordance with Plan Specialist's billing procedures. However, Member's out-of-pocket expense may vary depending on whether services are received from a SBA Plan Specialist or a Non-SBA Plan Specialist. Member responsibilities for obtaining services from these two categories of specialists are described below.

To fully understand payment responsibility for dental specialty services, Member should discuss the proposed treatment and its cost with the Plan Specialist prior to treatment. Availability of specific types of specialty services from a SBA or Non-SBA Plan Specialist depends on which types of dentists are SBA or Non-SBA Plan Specialists. Types of dentists who are SBA or Non-SBA Plan Specialists may vary from time to time in different parts of the Service Area. Availability of any specific dentist, or any specific type of dentist, as a SBA or Non-SBA Plan Specialist is not guaranteed. Listed Copayments apply only to SBA

Plan Specialists who perform the corresponding services listed in the Copayment Schedule. The SBA Plan Specialist used by Member may not perform all listed services.

Payment for all services received from a Non-Plan Specialist (at the Non-Plan Specialist's entire normal retail charge) is the responsibility of Member, except for limited benefits for Emergency Services as specifically stated in the EMERGENCY SERVICES Article of the Evidence of Coverage.

A). SBA Plan Specialist Services on Copayment Schedule: The following Copayment Schedule applies to covered services when they are provided by an SBA Plan Specialist. Member is responsible for paying the amount in the **Member Copayment** column either at the time the service is received or in accordance with SBA Plan Specialist's billing procedures.

ADA Code**	Service Description**	Member Copayment
	Appointments	
D0140	Limited oral evaluation - problem focused	35.00
D0150	Comprehensive oral evaluation - new or established patient (may only be obtained once in any 6 calendar months, except for medically necessary more frequent prophylaxis as determined by Member's Plan Dentist)	45.00
D0160	Detailed and extensive oral evaluation - problem focused, by report	67.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	35.00
D0180	Comprehensive periodontal evaluation - new or established patient	80.00
	Endodontics	
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	280.00
D3330	Endodontic therapy, molar (excluding final restoration)	395.00
D3346	Retreatment of previous root canal therapy - anterior	360.00
D3347	Retreatment of previous root canal therapy - premolar	525.00
D3348	Retreatment of previous root canal therapy - molar	545.00
D3410	Apicoectomy-Anterior	265.00
D3421	Apicoectomy-Premolar (first root)	280.00
D3425	Apicoectomy-Molar (first root)	210.00
D3430	Retrograde filling - per root	90.00
	Periodontics	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	355.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	100.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	495.00
D4261	Osseous surgery (including elevation of full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	215.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	100.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	70.00
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	80.00
	Oral Surgery	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	80.00
D7220	Removal of impacted tooth - soft tissue	105.00
D7230	Removal of impacted tooth - partially bony	135.00
D7240	Removal of impacted tooth - completely bony	200.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	220.00
D7250	Removal of residual tooth roots (cutting procedure)	75.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	180.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	130.00
D7510	Incision and drainage of abscess - intraoral soft tissue	105.00
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to	

ADA Code**	Service Description**	Member Copayment
	another procedure	185.00
	Other Services	
D9241	Intravenous moderate (conscious) sedation/analgesia - first 30 minutes	170.00

B). SBA Plan Specialist Services Not on Copayment Schedule/Non-SBA Plan Specialist Services: Dental services obtained from an SBA Plan Specialist, but not listed on the Copayment Schedule above, and dental services obtained from a Non-SBA Plan Specialist will be provided to Member at reduced charges. A 15% reduction from that Plan Specialist's normal retail charges applies to services obtained from a Plan Specialist who is an endodontist. A 25% reduction from that Plan Specialist's normal retail charges applies to services obtained from any other Plan Specialist (including, but not limited to, a Plan Specialist who is an orthodontist). Member is responsible for paying the entire reduced charge either at the time the service is received or in accordance with Plan Specialist's billing procedures.

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

***Service does not have an American Dental Association current dental terminology code or descriptor.

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.

UNITED DENTAL CARE OF ARIZONA, INC.

United Dental Care of Arizona, Inc.
2745 North Dallas Parkway, #500
Plano, Texas 75093
(800) 442-0911 or FAX (855)303-3908

Health Care Insurer Appeals Process Information Packet

CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS UNITED DENTAL CARE OF ARIZONA, INC. ("UDC") MAKES ABOUT YOUR HEALTH CARE.

Getting Information About the Health Care Appeals Process
Help in Filing an Appeal: Standardized Forms and Consumer Assistance From the Department of Insurance

UDC must send you a copy of this information packet when you first receive your policy, and within 5 business days after UDC receives your request for an appeal. When your insurance coverage is renewed, UDC must also send you a separate statement to remind you that you can request another copy of this packet. UDC will also send a copy of this packet to you or your treating provider at any time upon request. Just call our customer/member services number at (800) 443-2995 to ask.

At the back of this packet, you will find forms you can use for your appeal. The Arizona Insurance Department ("the Department") developed these forms to help people who want to file a health care appeal. You are not required to use them. UDC cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department's Consumer Assistance Office at (602) 364-2499 or 1(800) 325-2548 or call UDC at (800) 443-2995.

How to Know When You Can Appeal

When UDC does not authorize or approve a service or pay for a claim, UDC must notify you of your right to appeal that decision. Your notice may come directly from UDC, or through your treating provider.

Decisions You Can Appeal

You can appeal the following decisions:

1. UDC does not approve a service that you or your treating provider has requested.
2. UDC does not pay for a service that you have already received.
3. UDC does not authorize a service or pay for a claim because UDC says that it is not "dentally necessary."
4. UDC does not authorize a service or pay for a claim because UDC says that it is not covered under your dental plan, and you believe it is covered.
5. UDC does not notify you, within 10 business days of receiving your request, whether or not UDC will authorize a requested service.
6. UDC does not authorize a referral to a specialist.

Decisions You Cannot Appeal

You cannot appeal the following decisions:

1. You disagree with UDC's decision as to the amount of "allowable charges."
2. You disagree with how UDC is coordinating benefits when you have dental insurance with more than one insurer.
3. You disagree with how UDC has applied your claims or services to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with our decision to issue or not issue a policy to you.
6. You are dissatisfied with any rate increases you may receive under your insurance policy.
7. You believe UDC has violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that is not appealable according to this list, you may still file a complaint with the Arizona Department of Insurance, Consumer Affairs Division, 2910 N. 44 th, Second Floor, Phoenix, AZ 85018.

Who Can File An Appeal?

Either you or your treating provider can file an appeal on your behalf. At the end of this packet is a form that you may use for filing your appeal. You are not required to use this form, and can send UDC a letter with the same information. If you decide to appeal our decision to deny authorization for a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

Description of the Appeals Process

There are two types of appeals: an expedited appeal for urgent matters, and a standard appeal. Each type of appeal has 3 levels. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of the patient's condition.

Expedited Appeals (for urgently needed services you have not yet received)	**Standard Appeals** (for non- urgent services or denied claims)
Level 1 Expedited Dental Review	Informal Reconsideration[1]
Level 2 Expedited Appeal	Formal Appeal
Level 3 Expedited External Independent Dental Review	External Independent Dental Review

UDC makes the decisions at Level 1 and Level 2. An outside reviewer, who is completely independent from our company, makes Level 3 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3.

[1] **An informal reconsideration is not available for a denied claim.**

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Level 1. Expedited Dental Review

Your request: You may obtain Expedited Dental Review of your denied request for a service that has not already been provided if:

- You have coverage with UDC,
- UDC denied your request for a covered service, and
- Your treating provider certifies in writing and provides supporting documentation that the time required to process your request through the Informal Reconsideration and Formal Appeal process (about 60 days) is likely to cause a significant negative change in your dental condition. (At the end of this packet is a form that your provider may use for this purpose. Your provider could also send a letter or make up a form with similar information.) Your treating provider must send the certification and documentation to:

United Dental Care of Arizona, Inc.
Expedited Dental Review
2745 North Dallas Parkway, Suite 500
Plano, TX 75093

Our decision: UDC has 1 business day after UDC receives the information from the treating provider to decide whether UDC should change the decision and authorize your requested service. Within that same business day, UDC must call and tell you and your treating provider, and mail you our decision in writing. The written decision must explain the reasons for the decision and tell you the documents on which UDC based the decision.

If UDC denies your request: You may immediately appeal to Level 2.
If UDC grants your request: UDC will authorize the service and the appeal is over.
If UDC refers your case to Level 3: UDC may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2: Expedited Appeal

Your request: If UDC denies your request at Level 1, you may request an Expedited Appeal. After you receive UDC's Level 1 denial, your treating provider must immediately send a written request (to the same person and address listed above under Level 1) to tell UDC you are appealing to Level 2. To help your appeal, your provider

should also send UDC any more information (that the provider hasn't already sent UDC) to show why you need the requested service.

Our decision: UDC has 3 business days after UDC receives the request to make a decision.

If UDC denies your request: You may immediately appeal to Level 3.
If UDC grants your request: UDC will authorize the service and the appeal is over.
If UDC refers your case to Level 3: UDC may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: Expedited External, Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have only 5 business days after you receive UDC's Level 2 decision to send your written request for Expedited External Independent Review. Send your request and any more supporting information to:

United Dental Care of Arizona, Inc.
Expedited External, Independent Review
2745 North Dallas Parkway, Suite 500
Plano, TX 75093

Neither you nor your treating provider is responsible for the cost of any external independent review.

PLEASE NOTE: DENTAL NECESSITY REVIEWS ARE NOT PERFORMED UNDER THIS PLAN.

The process: There are two types of Level 3 appeals, depending on the issues in your case:
(1) Dental necessity
These are cases where UDC has decided not to authorize a service because UDC thinks the services you (or your treating provider) are asking for, are not dentally necessary to treat your problem. For dental necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review.

(2) Contract coverage
These are cases where UDC has denied coverage because UDC believes the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

Dental Necessity Cases

Within 1 business day of receiving your request, UDC must:

1. Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all dental records and supporting documentation used to render UDC's decision; a summary of the applicable issues including a statement of UDC's decision; the criteria used and clinical reasons for UDC's decision; and the relevant portions of UDC's utilization review guidelines. UDC must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 2 business days of receiving UDC's information, the Insurance Director must send all the submitted information to an external independent reviewer organization (the "IRO").

Within 5 business days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within 1 business day of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to UDC, you, and your treating provider.

The decision (dental necessity): If the IRO decides that UDC should provide the service, UDC must authorize the service. If the IRO agrees with our decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 1 business day of receiving your request, UDC must:

1. Mail a written acknowledgement of your request to the Insurance Director, you, and your treating provider.
2. Send the Director of Insurance: the request for review, your policy, evidence of coverage or similar document, all dental records and supporting documentation used to render UDC's decision, a summary of the applicable issues including a statement of UDC's decision, the criteria used and any clinical reasons for UDC's decision and the relevant portions of our utilization review guidelines.

Within 2 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to UDC, you, and your treating provider.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 5 business days to make a decision and send it to the Insurance Director. The Insurance Director will have 1 business day after receiving the IRO's decision to send the decision to UDC, you, and your treating provider.

The decision (contract coverage): If you disagree with Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If UDC disagrees with the Director's final decision, UDC may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for appeals from expedited Level 3 decisions.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Level 1. Informal Reconsideration

Your request: You may obtain Informal Reconsideration of your denied request for a service if:

- You have coverage with UDC,
- UDC denied your request for a covered service,
- You do not qualify for an expedited appeal, and
- You or your treating provider asks for Informal Reconsideration within 2 years of the date UDC first denied the requested service by calling, writing, or faxing your request to:

United Dental Care of Arizona, Inc.
Informal Reconsideration
2745 North Dallas Parkway, Suite 500
Plano, TX 75093

Claim for a covered service already provided but not paid for: You may not obtain Informal Reconsideration of your denied request for the payment of a covered service. Instead, you may start the review process by seeking Formal Appeal.

Our acknowledgement: UDC has 5 business days after UDC receives your request for Informal Reconsideration ("the receipt date") to send you and your treating provider a notice that UDC got your request.

Our decision: UDC has 30 days after the receipt date to decide whether UDC should change the decision and authorize your requested service. Within that same 30 days, UDC must send you and your treating provider UDC's written decision. The written decision must explain the reasons for the decision and tell you the documents on which UDC based the decision.

If UDC denies your request: You have 60 days to appeal to Level 2.
If UDC grants your request: The decision will authorize the service and the appeal is over.

If UDC refers your case to Level 3: UDC may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2. Formal Appeal

Your request: You may request Formal Appeal if: (1) UDC denies your request at Level 1, or (2) you have an unpaid claim and UDC did not provide a Level 1 review. After you receive our Level 1 denial, you or your treating provider must send UDC a written request within 60 days to tell UDC you are appealing to Level 2. If UDC did not provide a Level 1 review of your denied claim, you have 2 years from UDC's first denial notice to request Formal Appeal. To help UDC make a decision on your appeal, you or your provider should also send UDC any more information (that you haven't already sent UDC) to show why UDC should authorize the requested service or pay the claim. Send your appeal request and information to:

United Dental Care of Arizona, Inc.
Formal Appeals
2745 North Dallas Parkway, Suite 500
Plano, TX 75093

Our acknowledgement: UDC has 5 business days after UDC receives your request for Formal Appeal ("the receipt date") to send you and your treating provider a notice that UDC got your request.

Our decision: For a denied service that you have not yet received, UDC has 30 days after the receipt date to decide whether UDC should change its decision and authorize your requested service. For denied claims, UDC has 60 days to decide whether UDC should change its decision and pay your claim. UDC will send you and your treating provider its decision in writing. The written decision must explain the reasons for UDC's decision and tell you the documents on which UDC based its decision.

If UDC denies your request or claim: You have 60 days to appeal to Level 3.
If UDC grants your request: UDC will authorize the service or pay the claim and the appeal is over.
If UDC refers your case to Level 3: UDC may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: External, Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have **60 days** after you receive UDC's Level 2 decision to send UDC your written request for External Independent Review. Send your request and any more supporting information to:

United Dental Care of Arizona, Inc.
External, Independent Review
2745 North Dallas Parkway, Suite 500
Plano, TX 75093

Neither you nor your treating provider is responsible for the cost of any external independent review.

PLEASE NOTE: DENTAL NECESSITY REVIEWS ARE NOT PERFORMED UNDER THIS PLAN.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Dental necessity

These are cases where UDC has decided not to authorize a service because UDC thinks the services you (or your treating provider) are asking for, are not dentally necessary to treat your problem. For dental necessity cases, the independent reviewer is a provider retained by an outside independent review organization (IRO), procured by the Arizona Insurance Department, and not connected with UDC. For dental necessity cases, the provider must be a provider who typically manages the condition under review.

(2) Contract coverage

These are cases where UDC has denied coverage because UDC believes the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

Dental Necessity Cases

Within 5 business days of receiving your request, UDC must:

1. Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all dental records and supporting documentation used to render UDC's decision; a summary of the applicable issues including a statement of UDC's decision; the criteria used and clinical reasons for UDC's decision; and the relevant portions of UDC's utilization review guidelines. UDC must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 5 days of receiving UDC's information, the Insurance Director must send all the submitted information to an external independent review organization (the "IRO").

Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within 5 business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to UDC, you, and your treating provider.

The decision (dental necessity): If the IRO decides that UDC should provide the service or pay the claim, UDC must authorize the service or pay the claim. If the IRO agrees with UDC's decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 5 business days of receiving your request, UDC must:

1. Mail a written acknowledgement of your request to the Insurance Director, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all dental records and supporting documentation used to render UDC's decision; a summary of the applicable issues including a statement of UDC's decision; the criteria used and any clinical reasons for UDC's decision; and the relevant portions of UDC's utilization review guidelines.

Within 15 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to UDC, you, and your treating provider. If the Director decides that UDC should provide the service or pay the claim, UDC must do so.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business days after receiving the IRO's decision to send the decision to UDC, you, and your treating provider.

The decision (contract coverage): If you disagree with the Insurance Director's final decision on a coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If UDC disagrees with the Director's determination of coverage issues, UDC may also request a hearing at OAH. Hearings must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Obtaining Dental Records

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your dental records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your dental records. The dental records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your dental records only to yourself or your health care decision-maker.

Confidentiality: Dental records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your dental records may be disclosed only to people authorized to participate in the review process for the dental condition under review. These people may not disclose your dental information to any other people.

Documentation for an Appeal

If you decide to file an appeal, you must give UDC any material justification or documentation for the appeal at the time the appeal is filed. If you gather new information during the course of your appeal, you should give it to UDC as soon as you get it. You must also give UDC the address and phone number where you can be contacted. If the appeal is already at Level 3, you should also send the information to the Department.

The Role of the Director of Insurance

Arizona law (A.R.S. §20-2533(F)) requires "any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for appealable decisions, you must pursue the health care appeals process before the Insurance Director can investigate a complaint you may have against UDC based on the decision at issue in the appeal.

The appeal process requires the Director to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by insurers.
3. Receive, process, and act on requests from an insurer for External, Independent Review.
4. Enforce the decisions of insurers.
5. Review decisions of insurers.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings (OAH).
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at OAH.

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed," means your last known address.

UNITED DENTAL CARE OF ARIZONA, INC.

Please submit this form to:
Member Appeals
United Dental Care of Arizona, Inc.
2745 North Dallas Parkway, Suite 500
Plano, TX 75093

HEALTH CARE APPEAL REQUEST FORM

You may use this form to tell your insurer you want to appeal a denial decision.

Insured Member's Name _____ Member ID # _____

Name of representative pursuing appeal, if different from _____

Mailing Address _____ Phone # _____

City _____ State _____ Zip Code _____

Type of Denial: ☐ Denied Claim ☐ Denied Service Not Yet Received

Name of Insurer that denied the claim/service: _____

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing? _____

(Explain what you want your insurer to authorize or pay for.)

Explain why you believe the claim or service should be covered: _____

(Attach additional sheets of paper, if needed.)

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1-(800) 325-2548, or UDC at (800) 443-2995.

Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including: Dental records Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.) **Also attach the certification from your treating provider if you are seeking expedited review.

_____ _____

Signature of insured or authorized representative Date

UNITED DENTAL CARE OF ARIZONA, INC.

Please submit this form to:
Expedited Dental Reviews
United Dental Care of Arizona, Inc.
2745 North Dallas Parkway, Suite 500
Plano, TX 75093

PROVIDER CERTIFICATION FORM FOR EXPEDITED DENTAL REVIEWS
(You and your provider may use this form when requesting an expedited appeal.)

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 60 days) "is likely to cause a significant negative change in the patient's dental condition at issue."

PROVIDER INFORMATION

Treating Dentist/Provider _____
Phone # _____ FAX # _____
Address _____

PATIENT INFORMATION

Patient's Name _____ Member ID # _____
Phone # _____
Address _____
City _____ State _____ Zip Code _____

INSURER INFORMATION

Insurer Name _____
Phone # _____ FAX # _____
Address _____
City _____ State _____ Zip Code _____

• Is the appeal for a service that the patient has already received? ☐ Yes ☐ No
If "Yes," the patient must pursue the standard appeals process and cannot use the expedited appeals process. If "No," continue with this form.

• What service denial is the patient appealing? _____

• Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient. _____

Attach additional sheets if needed, and include: ☐ Dental records ☐ Supporting documentation

If you have questions about the appeals process or need help regarding this certification, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1 (800) 325-2548. You may also call UDC at (800) 443-2995.

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the informal reconsideration and formal appeal processes (about 60 days) is likely to cause a significant negative change in the patient's dental condition at issue.

Provider's Signature _____ Date _____