United Dental Care of Arizona, Inc.
Executive Office:
One Sun Life Executive Park
Wellesley Hills, MA 02481
(800-443-2995)

GROUP DENTAL SERVICE AGREEMENT

It is agreed between Earnhardt Management Company ("Group") and United Dental Care of Arizona, Inc. ("Company") as follows:

ARTICLE I
COVERAGE INFORMATION

1.1 **Group:**

Name: Earnhardt Management Company

Address: 7300 W Orchid Ln Chandler

City, State, ZIP Code: Chandler, AZ 85226

1.2 **Group Coverage Basis:**

☒ Contributory ☐ Non-Contributory

1.3 **Class of Members to be Covered:**

☐ Active ☐ Retirees

1.4 **Form of Coverage (choose one):**

☒ Group requests coverage under the Plus Plan with the Specialty Benefit Amendment (SBA).
☐ Group requests coverage under the Plus Plan without the Specialty Benefit Amendment (SBA).

1.5 **Total Group Prepayment Fee:** The Total Group Prepayment Fee is obtained by multiplying the number of Subscribers in each Fee Category by the Prepayment Fee for that category and adding the results. It is due and payable from Group as set out in this Agreement.

Fee Category	Plan Fee	+ SBA Fee	= Monthly Prepayment Fee
Subscriber	$ 12.05	$ 1.80	$ 13.85
Subscriber + Spouse	$ 20.39	$ 2.15	$ 22.54
Subscriber + Child(ren)	$ 28.27	$ 2.30	$ 30.57
Subscriber + Family	$ 33.37	$ 2.50	$ 35.87

1.6 **Group Administration Fee:**

☒ Not Applicable ☐ Applicable: A group Administration Fee of $0.00 for the initial month and $0.00 for each subsequent month is due and payable from Group with the Total Group Prepayment Fee.

1.7 **Initial Fee Guarantee Period:** Company will not change the Prepayment Fee for any Fee Category, or the applicability and amount of any Administration Fee, for the first 24 months during which Agreement is in effect (or for the entire period during which Agreement is in effect, if that is a shorter period).

1.8 **Effective Date, Initial Plan Year, Anniversary Date:** This Agreement becomes effective on the first day of October, 2019 ("Effective Date"). Agreement's initial Plan Year begins on the Effective Date and lasts for a period of 12 months, unless terminated before the end of that period by Company or Group. Agreement may be renewed pursuant to the renewal provisions of Agreement unless first terminated by Company or Group. If Agreement is renewed, Agreement's first Anniversary Date is the first day of October, 2020, with subsequent Anniversary Dates on the first day of October in each succeeding calendar year.

ARTICLE II
ENTIRE CONTRACT

2.1 **Entire Contract:** The Group Dental Service Agreement, Evidence of Coverage, Copayment Schedule and any applicable exhibits or amendments, hereinafter called "Agreement," form the entire agreement of the parties. This Agreement may be amended or modified. Changes must be in writing executed by Group and an authorized officer of Company.

ARTICLE III
DEFINITIONS

The following terms shall be defined as follows:

3.1 **Administration Fee:** The Group's Administration Fee (if applicable) is the fee paid by Group in addition to the Total Group Prepayment Fee.

3.2 **Anniversary Date:** The first Anniversary Date is the day after the initial Plan Year ends. The Anniversary Date occurs on the same date in each subsequent calendar year.

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

3.4 **Dental Emergency:** Bleeding, pain or acute infection requiring Emergency Services.

3.5 **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 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.

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

3.7 **Emergency Services:** Those dental services necessary to control bleeding, relieve pain, including local anesthesia, or eliminate acute infection. Medications that may be prescribed by the dentist but must be obtained through a pharmacy are excluded.

3.8 **Enrollment Form:** Shall mean the Group Enrollment Form.

3.9 **Fee Categories:** Member classifications used to determine the applicable Prepayment Fee for each Member's coverage under Agreement.

3.10 **Initial Fee Guarantee Period:** The period of time beginning on the Effective Date during which the Company agrees not to change the Prepayment Fee charged for any Fee Category, or the applicability or amount of any Administration Fee.

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

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

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

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

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

3.16 **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.

3.17 **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.

3.18 **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. If Group purchases the Specialty Benefit Amendment, 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 **PLAN 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 Plan Specialists (or SBA or Non-SBA Plan Specialists) depends on which types of dentists are Plan Specialists. Company cannot guarantee the availability of any specific type of dentist as a Plan Specialist (or an SBA or Non-SBA Plan Specialist). Types of dentists who are Plan Specialists (or SBA or Non-SBA Plan Specialists) may vary from time to time in different parts of the Service Area. If Group purchases the Specialty Benefit Amendment, the Copayments listed in the **PLAN 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.

3.19 **Plan Year:** The initial Plan Year begins on the Effective Date and lasts until the day before the first Anniversary Date. Each subsequent Plan Year begins on the Anniversary Date and lasts for a period of twelve (12) calendar months.

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

3.21 **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.

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

3.23 **Total Group Prepayment Fee:** The sum of the Prepayment Fees for coverage of all Members.

ARTICLE IV
PREPAYMENT FEE, ADMINISTRATION FEE, AND ELIGIBILITY

4.1 **Prepayment Fee and Administration Fee:** Group shall pay Company the Prepayment Fee for each enrolled Member. Group shall also pay Company the Administration Fee (if applicable) at the same time and in the same manner as the Prepayment Fees. The Total Group Prepayment Fee and (if applicable) Administration Fee shall be paid in a single payment. This starts on the Effective Date and continues on the first day of each month thereafter while Agreement is in force.

After the Initial Fee Guarantee Period, Company reserves the right to change any Prepayment Fee and to change the applicability and amount of any Administration Fee upon thirty (30) days written notice to Group. Payment of any amended Prepayment Fee or Administration Fee indicates acceptance of the amended Prepayment Fee or Administration Fee.

4.2 **Provision of Plan Benefits/Plan Providers:** Group acknowledges that unless there is a need for Emergency Services, Agreement provides exclusively for services performed by a Plan Provider. Company shall not have any liability due to treatment by any Non-Plan Provider, physician, hospital, other person, institution or group. Each Member shall select a Plan Dentist from Plan Dentist Directory furnished by Company to Group. Agreement provides for services only. It is not an insurance policy. It does not reimburse Member or Group, except for Emergency Services.

4.3 **Eligibility List:** Group shall be responsible for providing Company, by the 20th day of the month, the names and other identifying data for each Member to be covered in order for eligibility to be effective on the 1st day of the succeeding month. Group shall identify those Members who are newly eligible to receive Plan Benefits. Group shall name the Plan Dentist selected by each Member who is newly eligible. Group shall identify those Members whose coverage will terminate. Group shall be responsible for payment of Prepayment Fees due Company for Members. Payment shall continue until notice of a change in eligibility is provided by Group to Company.

4.4 **Eligibility:** Group shall determine eligibility for participation in Plan. Company may rely upon such decision until Group provides notice of a change in eligibility. Any disputes or inquiries from Members regarding eligibility, including renewal or continuation of coverage, shall be referred by Company to Group. Group shall advise Company of its decision. Each Member must work or live in Plan Service Area in order to participate in Plan.

Subscriber and his Dependent(s) are eligible to become Members of Plan during the open enrollment period set by Group. 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.

4.5 **Coverage of Members:** The Effective Date of coverage for Subscriber or Dependent shall be the first day of the month after written notice and payment of the Prepayment Fee is accepted by Company. Each Subscriber or Dependent enrolled in Plan and whose proper 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 enrolled in Plan and whose proper Prepayment Fee has been accepted by Company after the 20th day, but by the last day, of the month will be covered beginning the first day of the second following month.

4.6 **Enrollment Forms:** Each Member shall complete an Enrollment Form or suitable proof of enrollment.

ARTICLE V
BENEFITS

5.1 **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 to Group.

5.2 **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.

5.3 **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.

ARTICLE VI
MEMBER/PLAN PROVIDER RELATIONSHIP

6.1 **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.

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

6.3 **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 VII
ADMINISTRATION

7.1 **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.

7.2 **Grievance Resolution Procedures:** Any inquiries, complaints or grievances 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. Grievance resolution procedures and appeals processes are outlined in the Health Care Insurer Appeals Process Information Packet included with the Evidence of Coverage. Additional or replacement copies of the Health Care Insurer Appeals Process Information Packet may be obtained by contacting the Company.

7.3 **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. Either Member or Plan Dentist may request a change of Plan Provider selection by contacting Company.

B. Plan Specialist:

Without Specialty Benefit Amendment: If Member requires specialty services covered under Plan that cannot be provided by Member's selected Plan Dentist, Member may obtain services from a Plan Specialist. No referral from the selected Plan Dentist is needed. Plan does not cover services received from Non-Plan Providers.

With Specialty Benefit Amendment: Under the Specialty Benefit Amendment, Member may obtain services from a Plan Specialist. No referral from the selected Plan Dentist is needed. Member's out-of-pocket amount may vary depending on whether services are received from an SBA Plan Specialist or a Non-SBA Plan Specialist. Plan does not cover services received from Non-Plan Providers.

7.4 **Emergency Services:** Procedures for obtaining Emergency Services are in the Evidence of Coverage. A copy of the procedures may also be obtained by contacting Company.

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

ARTICLE VIII
TERM AND TERMINATION

8.1 **Term:** After the initial Plan Year, each Plan Year of Agreement shall have a twelve month term. It shall be automatically renewed at the Anniversary Date unless otherwise terminated.

8.2 **Termination:** Agreement may be terminated as follows:

A. During the initial Plan Year by Company:

1. for failure to pay proper monthly Prepayment Fees or (if applicable) the proper monthly Administration Fee prior to the 10th of the month in which such fees are due, subject to a thirty (30) day grace period;

2. for fraud or misrepresentation of fact in obtaining coverage under Plan, effective immediately upon prior written notice to Group;

3. for material breach of any provision of Agreement, upon thirty (30) days written notice to Group.

B. At Anniversary Date, upon sixty (60) days prior written notice by Company to Group or by Group to Company.

C. After the initial Plan Year, without cause, upon sixty (60) days prior written notice by Company to Group or by Group to Company.

8.3 **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.

8.4 **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 Enrollment Form submitted by Member, coverage will terminate immediately upon written notice. This provision will not be enforced after two (2) years from the time Member's coverage begins.

D. If Group and/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, including but not limited to Copayments, laboratory fees or missed appointment fees, Company reserves the right to terminate coverage upon sixty (60) days written notice. Prepayment Fees received on account of terminated Member, which apply to period after termination date shall be refunded to Group. Thereafter, Company shall have no further liability or responsibility to Member.

F. If Member, after reasonable efforts, is unable to establish and maintain a satisfactory dentist-patient relationship with Plan Provider, 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.

8.5 **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 continuation of coverage beyond the date Member's coverage would otherwise terminate, the following applies. Agreement shall be deemed to allow continuation of coverage as necessary to comply with the provisions of applicable statutes. Member should contact Group concerning eligibility.

ARTICLE IX
GENERAL PROVISIONS

9.1 **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.

9.2 **Waiver:** The waiver by either party of one or more defaults shall not be construed as a waiver of any other or future default. This applies to any covenant or other condition contained in Agreement. Only an authorized officer of Company may waive any conditions or restrictions of Agreement. Only an authorized officer of Company can amend Agreement, extend time for making a payment or bind Company by making any promise or representation. Such promise or representation shall be in writing. No change in Agreement shall be valid unless endorsed by an authorized officer of Company.

9.3 **Notice:** Notice to either party under this Agreement shall be in writing. Notice shall be sent to the address shown in Agreement.

9.4 **Terms:** Throughout Agreement, the singular shall include the plural and the plural the singular. The masculine shall include the neuter and feminine. The neuter shall include the masculine and feminine.

9.5 **Invalidity:** If any provision of Agreement is determined to be illegal or invalid, all other provisions remain valid. This is true unless the illegality or invalidity prevents the purpose of Agreement from being realized.

9.6 **Assignment of Agreement:** No assignment of Agreement is binding upon Company unless Company agrees to it in writing. Any such assignment shall not waive Company's right to withhold its consent to any other assignment. There may occur a merger or acquisition involving Group. If so, Agreement shall remain in force with the surviving entity for the balance of the term of Agreement.

9.7 **Acknowledgment:** Each of the parties acknowledges that it has read Agreement and understands its contents. Each party acknowledges it executes Agreement voluntarily.

9.8 **Authority:** Group represents it has the authority under applicable law and its charter instrument to execute Agreement.

9.9 **Worker’s Compensation:** Agreement is not in place of and does not affect any requirement for coverage by Worker's Compensation.

9.10 **Governing Law:** Agreement shall be governed by and construed according to laws of the State of Arizona.

9.11 **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.

9.12 **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.

9.13 **Attorney's Fees and Costs:** If Group defaults in any of its obligations, Group agrees it will pay all of Company's costs to enforce its rights hereunder. This includes, but is not limited to, Company's attorneys' fees and court costs.

9.14 **ERISA:** If Group is regulated under the Employee's Retirement Income Security Act of 1974 (ERISA), Company will work with Group in supplying Group with any information in its possession in meeting any reporting requirements. Company is not and shall not be the chosen administrator or fiduciary for reporting requirements.

ARTICLE X
NON-INSURANCE DISCOUNT VISION PROGRAM

10.1 **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).

IN WITNESS WHEREOF, the parties have affixed their signatures to this Agreement.

COMPANY: United Dental Care of Arizona, Inc.	GROUP: Earnhardt Management Company
By: Stacia N. Almquist	By:
Signature	Signature
Stacia N. Almquist, President	
Print Name and Title	Print Name and Title
July 17, 2019	
Date	Date

DEPENDENT AGE 26
AMENDMENT

This Amendment to the Group Dental Service Agreement ("Agreement") between Earnhardt Management Company ("Group") and United Dental Care of Arizona, Inc. ("Company") shall be attached to and form part of the Agreement. It is applicable to the Group and all enrolled Members. All provisions of the Agreement shall remain in full force and effect except as follows:

The definition of "Dependent" is changed to read 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 N. Almquist, President
_____
Print Name and Title

July 17, 2019
_____
Date

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 _____