

# BEST'S RATING REPORT



## Sun Life Assurance Company of Canada

1 York Street, Toronto, Ontario, Canada M5J 0B6

**AMB #:** 007101

**NAIC #:** N/A

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# Sun Life Assurance Company of Canada

**Report Release Date:**

January 16, 2019

**Rating Effective Date:**

December 14, 2018

**Disclosure Information:** View A.M. Best's [Rating Disclosure Form](#)

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**Ultimate Parent:** [050913 - Sun Life Financial Inc.](#)
**A.M. Best Rating Unit:** [067413 - Sun Life Assurance Company of Canada](#)

## Best's Credit Ratings:

Rating Effective Date: December 14, 2018

<b>Best's Financial Strength Rating:</b>	A+	<b>Outlook:</b>	Stable	<b>Action:</b>	Affirmed
<b>Best's Issuer Credit Rating:</b>	aa-	<b>Outlook:</b>	Stable	<b>Action:</b>	Affirmed

## Five Year Credit Rating History:

Date	Best's Financial Strength Ratings			Best's Issuer Credit Ratings		
	Rating	Outlook	Action	Rating	Outlook	Action
12/14/2018	A+	Stable	Affirmed	aa-	Stable	Affirmed
12/19/2017	A+	Stable	Affirmed	aa-	Stable	Affirmed
12/02/2016	A+	Stable	Affirmed	aa-	Stable	Affirmed
07/09/2015	A+	Stable	Affirmed	aa-	Stable	Affirmed
05/01/2014	A+	Stable	Affirmed	aa-	Stable	Affirmed

## Rating Rationale:

The following text is derived from Best's Credit Report on Sun Life Assurance Company of Canada (AMB#067413)

### Balance Sheet Strength: Strongest

- Very strong regulatory capital profile that is supportive of growth initiatives in all geographic territories and market segments.
- Prudent use of financial and operating leverage, which enhances balance sheet opportunities and new business growth that is supported by solid risk-based capital levels.
- Appropriate use of reinsurance with affiliated and non-affiliates reinsurers.

- Strong liquidity profile supported by positive earnings and a highly liquid investment portfolio backed by highly rated bonds.

## Operating Performance: Strong

- Stable trend of operating performance with some volatility related to managing a complex global organization.
- Operating performance is expected to provide a stable trend of consistent earnings compared to prior years as previous acquisitions have been reflected in previous financial results.
- Underwriting is subject to periodic volatility related to actuarial assumption changes in reserve modeling and management actions.

## Business Profile: Favorable

- Sun Life has leading market share in the United States, Canada, and Asian marketplaces.
- The company has been able to demonstrate the ability to expand in various markets while continuing to adhere to a lower product risk profile within group benefits, group retirement, individual life and wealth segments.
- Execution risk with regard to growth and expansion strategies does exist as part of the business profile of the company pertaining to asset management segments in Asia.

## Enterprise Risk Management: Appropriate

- ERM is heavily supported by both quantitative and qualitative measures, which are embedded as part of the company's risk culture.
- Product design and pricing are supported by the company's ERM program and management expertise
- Given the international footprint of the company, a highly sophisticated and integrated ERM program is expected to be part of the company's operations.

## Outlook

The stable outlooks are supported by the company's strongest balance sheet assessment, strong operating earnings, and favorable business profile.

## Rating Drivers

Negative ratings action could occur if there is a substantial deterioration in operating performance.

Negative ratings action could occur if there is a substantial deterioration in risk adjusted capitalization.

## Financial Data Notes:

**Time Period:** Annual - 2017

**Status:** A.M. Best Quality Cross Checked

**Data as of:** N/A

**Key Financial Indicators:****Key Financial Indicators (000)**

	Year End - December 31				
	2017	2016	2015	2014	2013
Assets (\$000)	233,329,012	224,920,654	211,704,090	190,585,119	166,055,847
Capital & Equity	16,825,799	16,601,603	16,317,916	14,095,965	12,841,071
AOCl (\$000)	917,951	1,362,557	2,151,822	1,098,318	430,491
Net Premiums Written (\$000)	9,576,244	9,213,746	7,105,502	6,439,751	2,973,790
Net Investment Income (\$000)	5,236,433	5,594,628	2,982,972	7,981,347	393,290
Income Before Attribution to Participating Policyholders (\$000)	1,792,807	1,930,864	1,801,975	1,566,241	1,264,436

Source: Bestlink - Best's Statement File - L/H, Canada

Local Currency: Canadian Dollar

**Credit Analysis:****Balance Sheet Strength****Capitalization:****Capital Generation Analysis**

	Year End - December 31				
	2017	2016	2015	2014	2013
Pre-tax Adjusted Gain (\$000)	1,990,677	2,173,120	1,996,479	1,836,813	1,310,982
Income Taxes (\$000)	197,870	242,256	194,504	270,572	46,546
Other Changes (\$000)	-1,568,611	-1,647,177	419,976	-311,347	-154,650
Change in Capital & Equity (\$000)	224,196	283,687	2,221,951	1,254,894	1,109,786
Capital & Equity (%)	1.4	1.7	15.8	9.8	9.5

Source: Bestlink - Best's Statement File - L/H, Canada

Local Currency: Canadian Dollar

**Liquidity Analysis**

	Year End - December 31				
	2017	2016	2015	2014	2013
Mtge & Real Estate to Cap & Equity (%)	125.7	121.4	117.1	122.6	129.0

**Capitalization: (Continued...)****Liquidity Ratios (%)**

	Year End - December 31				
	2017	2016	2015	2014	2013
Quick Liquidity (%)	5.3	5.4	6.1	5.0	5.2
Current Liquidity (%)	59.7	60.2	61.0	61.6	59.8

Source: Bestlink - Best's Statement File - L/H, Canada

**Leverage Analysis (%)**

	Year End - December 31				
	2017	2016	2015	2014	2013
Capital & Equity to Liabilities	7.8	8.0	8.4	8.0	8.4
Reinsurance Leverage	92.4	89.6	80.8	86.7	84.7
NPW to Capital	0.6	0.6	0.4	0.5	0.2
Change in NPW	3.9	29.7	10.3	116.6	-47.6

Source: Bestlink - Best's Statement File - L/H, Canada

**Operating Performance****Underwriting Results:****Profitability Test (%)**

	Year End - December 31					5-YR Avg/Total
	2017	2016	2015	2014	2013	
Benefits Paid to NPW	75.1	76.0	75.3	78.6	153.8	82.6
Commissions & Expenses to NPW	38.9	38.7	37.5	31.2	58.1	38.8
Net Income to Total Assets	1.2	1.4	1.4	1.4	1.2	1.3
Net Income to Total Revenues	10.8	11.8	16.0	10.2	29.7	13.1
Net Income to Equity	10.7	11.7	11.8	11.6	10.3	11.3
Yield on Invested Assets	5.60	6.12	3.46	10.98	0.57	5.37

Source: Bestlink - Best's Statement File - L/H, Canada

**Business Profile**

The following text is derived from Best's Credit Report on Sun Life Assurance Company of Canada (AMB# 067413):

Sun Life Assurance Company of Canada (SLA) is the Canadian insurance company and lead insurance company for Sun Life Financial Inc. (SLF).

The key life insurance subsidiary of Sun Life Financial Inc. (SLF) is Sun Life Assurance Company of Canada (SLA). SLA owns Sun Life and Health Insurance Company (U.S.) (SLHIC), which markets group life and A&H products. With the sale of Sun Life Assurance

Company of Canada (U.S.) (SLUS) and Sun Life Insurance and Annuity Company of New York (SLNY) in August 2013, SLHIC became the U.S. marketing arm in New York.

SLA maintains a market leading position in Canada through their workplace segment. SLA has three main business units: Individual Insurance & Wealth, Group Benefits and Group Retirement Services. These units offer a full range of protection, wealth accumulation and income products and services to individuals in their communities and their workplaces. SLA also has investments in the Canadian asset management sector.

GB provides life, dental, drug, extended health care, disability and critical illness benefits programs to employers of all sizes. In addition, voluntary benefits are offered directly to individual plan members, including post-employment life and health plans to members exiting their plan. Products are marketed and distributed across Canada by sales representatives in collaboration with independent advisors, benefits consultants and the Sun Life Financial Career Sales Force (CSF).

While each of its business units remain focused on their respective markets, SLA recognizes the opportunity to serve its clients through the combination of some aspects of these businesses. This has led to the formation of SLA's Total Benefits offering for group clients and customer solutions, which addresses the needs of individual and group clients as they do business with the company through the exclusive CSF. The CSF provides solutions to members at the worksite while they are enrolling in group plans and through ongoing services at important life events including transition guidance for members changing jobs or retiring. Client Solutions (CS) business was created in January 2009 to address these needs and help manage retirement planning while giving them access to products such as term life insurance, health coverage, home and auto and travel insurance, as well as providing solutions to members at the worksite while enrolling in group plans, and changing jobs. The Defined Benefit Solutions (DBS) business, which falls under GRS, provides de-risking solutions to pension clients through annuity buyout and liability driven investment solutions. SLA's Canadian Individual Insurance and Wealth business comprises permanent life, participating life, term life, universal life, critical illness, long-term care and personal health insurance. Savings and retirement products include internally manufactured Sun Life Global Investments (Canada) Inc. (SLGIC) mutual funds, third-party mutual funds, segregated funds, accumulation annuities, guaranteed investment certificates and payout annuities. These products are marketed through a multi-channel distribution model consisting of the CSF and third-party distribution channels, such as independent insurance and mutual fund licensed brokers and broker-dealers. Certain products, including accidental death insurance and personal health insurance, are marketed directly to retail clients in partnership with advisor channels.

SLF U.S. has three business units: Group Benefits, International and In-force Management. Group Benefits provides protection solutions to employers and employees including group life, disability, medical stop-loss and dental insurance products, as well as a suite of voluntary benefits products. International offers individual life insurance products to high net worth clients in international markets. In-force Management includes certain closed individual life insurance products, primarily universal life and participating whole life insurance. SLF acquired Assurant Inc.'s (Assurant) employee benefits business recently which created the sixth largest group benefits business in the U.S., with the combined business having one of the broadest product portfolios in the industry. The transaction adds significant new capabilities to the SLF U.S. Group Benefits business, including a strong dental business with the second largest proprietary provider network in the U.S. and will also significantly increase the size and scale of the SLF U.S. Group Benefits business.

Sun Life Investment Management Inc. (SLIM) in Canada. SLIM was created to help Canadian pension funds and other investors seeking additional yield in a low return environment by giving them access to SLF's investments in commercial mortgages, private fixed income and real estate, as well as liability-driven investment (LDI) capabilities. SLF acquired the New York-based firm Ryan Labs Inc. (Ryan Labs), specializing in liability-driven investment (LDI) and total return fixed income strategies, and adding \$5.1 billion under management and expanding SLF's footprint in the U.S. This purchase is anticipated to build the business overseeing bonds for investors including pension funds and institutional clients. SLF acquired the Bentall Kennedy group of companies, a real estate investment manager operating in Canada and the U.S., which provides specialized real estate investment management and real estate services, including property management and leasing. SLF acquired Prime Advisors, Inc. (Prime), an investment management firm specializing in customized fixed income portfolios primarily for U.S. insurance companies. With the addition of Prime, together with the recent acquisitions of the Bentall Kennedy group of companies and Ryan Labs, SLIM's third-party assets under management grew. This growth provided SLF an excellent platform for serving institutional clients and expanding business in the U.S.

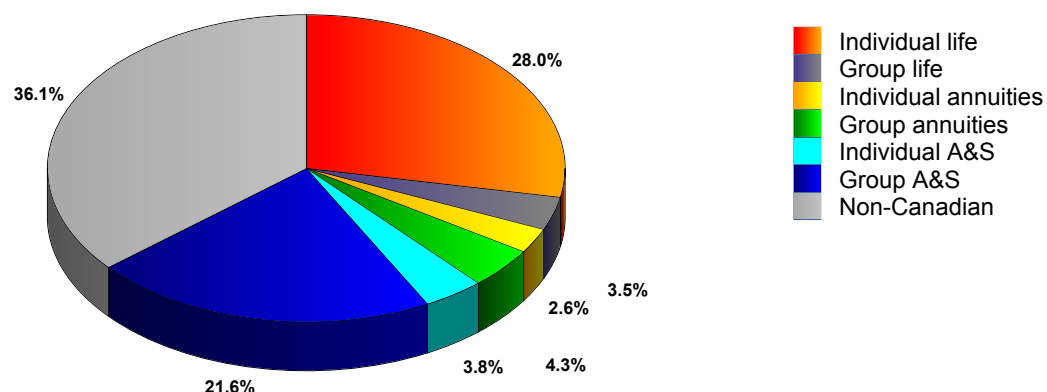
MFS, headquartered in Boston, MA, is a global investment management company. MFS has investment teams located in Hong Kong, London, Mexico City, Sao Paulo, Singapore, Sydney, Tokyo, Melbourne and Toronto and offer products and services that address the varying needs of retail and institutional investors over time. Retail investors have access to MFS' advisory services through a broad selection of financial products including mutual funds, variable annuities, separate accounts, college and retirement savings plans, and offshore investment products. These products are distributed through financial intermediaries that provide sales support, product administration and client services. MFS provides asset management services to institutional clients for corporate retirement plans, separate accounts, public or government funds and insurance company assets. Institutional clients are serviced through a direct sales force and a network of independent consultants. MFS' strategy has expanded in recent years to include institutional product sales. Over the last few years, MFS has initiated several institutionally focused investment products, designed to better meet the market diversification of investment performance linked to an index and investment performance based on the management of investment vehicles.

SLF Asia operates in seven markets, through subsidiaries, joint ventures (JV) and local partners in the Philippines, Hong Kong, Indonesia, India, China, Vietnam and Malaysia. It provides individual life and health insurance as well as group life insurance and savings products in the markets in which it operates as well as pension and retirement products in Hong Kong and India, and mutual

funds in the Philippines and India. These protection and wealth management products are distributed to middle and upper income individuals, employer / employee groups and affinity clients. SLF Asia's parent is Sun Life Assurance.

The Corporate segment includes the results of SLF U.K and Corporate Support operations that consist of the company's run-off reinsurance business as well as investment income, expenses, capital and other items not allocated to Sun Life Financial's other business segments. Since 2008, SLF began consolidating the results of SLF Reinsurance into Corporate Support as reinsurance business is a closed block that consists of reinsurance assumed from other insurers with coverages of individual disability income, long-term care, group long-term disability and personal accident and medical coverage, as well as guaranteed minimum income and death benefit coverage. The block also includes group long-term disability and personal accident which are 100% retroceded. Discontinued Operations in Corporate relate to Corporate Support only.

## 2017 Top Product Lines of Business (Net Premiums Written)



Source: Bestlink - Best's Statement File - L/H, Canada

## 2017 By-Line Business

Product Line	Direct Premiums Written		Reinsurance Premiums Assumed		Reinsurance Premiums Ceded		Net Premiums Written	
	(\$000)	(%)	(\$000)	(%)	(\$000)	(%)	(\$000)	(%)
Individual life	3,529,004	21.2	...	...	844,590	10.9	2,684,414	28.0
Group life	958,508	5.8	370	0.1	622,386	8.0	336,492	3.5
Individual annuities	589,577	3.5	...	...	336,908	4.4	252,669	2.6
Group annuities	1,868,244	11.2	...	...	1,453,213	18.8	415,031	4.3
Individual A&S	450,563	2.7	...	...	82,440	1.1	368,123	3.8
Group A&S	4,431,326	26.7	...	...	2,366,703	30.6	2,064,623	21.6
Non-Canadian	4,793,609	28.8	697,273	99.9	2,036,177	26.3	3,454,705	36.1
Total	16,620,831	100.0	697,643	100.0	7,742,417	100.0	9,576,244	100.0

Source: Bestlink - Best's Statement File - L/H, Canada

Local Currency: Canadian Dollar

## Geographical Breakdown By Direct Premium Writings

	2017	2016	2015	2014	2013
Ontario	5,659,036	4,902,423	4,330,344	4,001,675	4,113,255
Out of Canada	4,793,609	4,736,224	4,354,989	4,033,279	3,963,750
Quebec	2,307,252	2,413,111	2,123,830	2,323,904	1,792,673
Alberta	1,390,587	1,265,165	1,264,026	1,226,960	1,209,105
British Columbia	1,253,039	1,304,120	1,085,580	1,063,745	982,102
Saskatchewan	316,716	294,926	266,095	256,771	276,842
Nova Scotia	251,201	211,834	282,386	213,686	213,579
Manitoba	216,167	216,943	413,253	183,463	177,614
New Brunswick	170,704	166,608	389,972	166,589	156,353
Newfoundland and Labrador	139,408	132,017	260,554	145,447	173,561
All Other	123,112	106,570	143,909	129,703	141,065
<b>Total</b>	<b>16,620,831</b>	<b>15,749,941</b>	<b>14,914,938</b>	<b>13,745,222</b>	<b>13,199,899</b>

Source: Bestlink - Best's Statement File - L/H, Canada

Local Currency: Canadian Dollar



## Financial Statements:

### Balance Sheet:

### Balance Sheet:

Admitted Assets	Year End - December 31	
	2017 (\$000)	2016 (\$000)
Bonds	58,821,900	57,934,252
Preferred shares	172,490	185,722
Common shares	4,725,152	4,681,102
Mortgage loans	14,588,650	14,270,358
Property & equipment	6,909,615	6,278,863
Contract loans	2,733,809	2,728,701
Joint ventures	656,528	549,780
Cash & short-term inv	3,663,795	3,791,122
Accounts receivable	7,458,465	7,578,845
Accrued invest income	712,630	690,280
Other assets	43,924,286	45,047,080
Segregated funds	88,961,692	81,184,549
Total Assets	233,329,012	224,920,654

Liabilities & Surplus	Year End - December 31	
	2017 (\$000)	2016 (\$000)
Gross actuarial liabilities	99,454,547	97,658,355
Accounts payable	10,058,308	10,341,761
Other policy liabilities	5,841,672	5,697,582
Other debt	7,327,592	8,780,018
Other liabilities	4,858,529	4,656,786
Deferred income tax	873	...
Segregated funds	88,961,692	81,184,549
Total Liabilities	216,503,213	208,319,051
Policyholders equity	606,998	395,481
Shareholders equity	16,218,801	16,206,122
Total Liabilities and Equity	233,329,012	224,920,654

Source: Bestlink - Best's Statement File - L/H, Canada

Local Currency: Canadian Dollar

## Summary of Operations:

### Summary of Operations (000)

Statement of Income	2017 (\$000)	Expenses	2017 (\$000)
Premiums:		Benefits paid	7,193,246
Individual life	3,434,207	Change in reserves	2,531,286
Individual annuities	264,737	Plcyhldr divs & refunds	790,042
Group life	1,191,871	Trans from/to oth funds	-119,585
Group annuities	443,145	Commissions	506,571
Acc & sickness group	3,873,974	Interest expenses	429,655
Acc & sickness individual	368,123	Gen exp & taxes	3,214,696
Total premiums	9,576,244	Other expenses	95,691
Net investment income	5,236,433		
Misc income	1,819,602		
Total	16,632,279	Total	14,641,602
		Income before income tax and other items	1,990,677
		Provision for income taxes	197,870
		Income before attribution to participating policies and other items	1,792,807
		Income attributed to participating policies and other items	216,711
		Net income	1,576,096

Source: Bestlink - Best's Statement File - L/H, Canada

Local Currency: Canadian Dollar

# Sun Life Assurance Company of Canada

**Report Revision Date:**

January 16, 2019

**Company Attributes:**

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<b>Industry:</b>	Insurance
<b>Business Type:</b>	Life, Annuity, and Accident
<b>Entity Type:</b>	Operating Company
<b>Organization Type:</b>	Stock
<b>Business Status:</b>	In Business - Actively Underwriting
<b>Marketing Type:</b>	Career Agent
<b>Financial Size:</b>	XV (\$2 Billion or greater)

**Company History:****Date Incorporated:** 03/18/1865**Date Commenced:** 05/01/1871**Domicile:** Canada: Ontario

Originally incorporated as The Sun Insurance Company of Montreal in 1865, the name was changed in 1871 to Sun Mutual Life Insurance Company of Montreal, and in 1882 the present title Sun Life Assurance Company of Canada (SLA or the Company) was adopted. In 1962, the company was organized as a mutual life insurance company. On March 22, 2000, the company completed its demutualization. Sun Life Financial Inc. (SLF) is the publicly traded holding company for its principal Canadian life insurance subsidiary, SLA and is traded on the major stock exchanges in Toronto, New York and the Philippines.

SLF has made several business transactions to enhance its overall evolving business model.

SLF acquired Clarica Life Insurance Company (Clarica Life) and its wholly owned subsidiary, Clarica Life Insurance Company-U.S. in 2002, as an all-stock transaction valued at approximately \$6.9 billion CAD. Clarica Life Insurance Company-U.S. was subsequently sold in early 2003 and Clarica Life Insurance Company was merged into Sun Life at the end of 2002. At the time of the transaction, based on assets under management, Clarica Life was Canada's fourth largest life insurer with favorable market positions in a number of major Canadian business segments. The consolidation created one of Canada's largest life insurance companies, with very strong market positions in all major protection and wealth accumulation business segments in Canada.

In 2002, SLF acquired an economic interest in CI in exchange for its subsidiary, Spectrum Investment Management Limited (Spectrum), and Clarica Diversico Ltd. (Diversico), the mutual fund subsidiary of Clarica Life.

In 2007, SLF introduced an integrated brand strategy to reduce brand duplication and complexity in the Canadian market. This strategy included retiring the Clarica brand and aligning its career sales force with the Sun Life brand.

On May 31, 2007, the Company completed its acquisition of Genworth Financial Inc.'s U.S. Employee Benefits Group (Genworth EBG Business) for \$725 million. The SLF U.S. group business combined with the Genworth EBG Business and became the SLF Employee Benefits Group, offering customers group life, disability, dental and stop loss insurance, and voluntary worksite products. This acquisition added scale and scope to the SLF U.S. Employee Benefits Group business and solidified its top ten leadership position in the important U.S. employee benefits industry. In addition, the increased access to markets, broadened product and service offerings and strengthened distribution platform positioned SLF for long-term growth.

On June 22, 2007, the Company purchased approximately two million of additional trust units of CI Financial Income Fund for \$66 million in order to maintain its existing combined interest in CI Financial Income Fund and Canadian International LP (collectively, CI Financial). SLF's interest in CI Financial had decreased slightly as a result of CI Financial's purchase of Rockwater Capital Corporation in the second quarter of 2007.

On November 7, 2007, the Company sold the U.S. subsidiaries that comprised of the Independent Financial Marketing Group business to LPL Holdings, Inc. The sale had no material effect on the 2007 financial results.

**Company History: (Continued...)**

On February 29, 2008, the Company sold Sun Life Retirement Services (U.S.), Inc., a 401(k) plan administration business in the United States, to The Hartford Financial Services LLC (Hartford). The sale had no material effect on the 2008 financial results. The sale price was \$47 million. Hartford acquired over 400 employees, \$17 billion in AUM across roughly 6,000 plans and 465,000 plan participants.

On December 12, 2008, SLF sold its 37% interest in CI Financial Income Fund to Bank of Nova Scotia for \$2.2 billion CAD. The proceeds included \$1.55 billion CAD in cash and the balance in common and preferred shares of Bank of Nova Scotia.

On July 15, 2009, SLF and CIMB Group received regulatory approval to form a joint venture to distribute SFL's life, accident and health insurance products through the 600-plus retail branches of PT Bank CIMB Niaga in Indonesia.

On July 29, 2009, the Company announced the restructuring of its insurance JV in China. During the third quarter of 2010, SLF repositioned the company in China when it completed its restructuring initiatives, reducing its ownership from 50% to about a 24.9% interest. SLF will continue to provide its international governance, risk management and actuarial expertise and standards to Sun Life Everbright. The repositioning of Sun Life Everbright as a domestic insurer in the market will provide additional avenues of growth in China's financial services market and enable the company to fully leverage China Everbright Bank's broad distribution capabilities.

On October 1, 2009, the Company completed the acquisition of the United Kingdom operations of Lincoln National Corporation for \$387 million. The purchase price was subject to adjustment related to market and business performance prior to October 1, 2009. There were no material adjustments to the purchase price allocation of 2010. The acquisition increased Sun Life U.K.'s assets under management over 60% to \$20 billion and doubled the number of policies in force to 1.1 million.

On December 31, 2010, the Company completed the sale of its reinsurance business to Berkshire Hathaway Life Company of Nebraska.

On October 25, 2011, SLF completed the acquisition of 49% of Grepalife Financial Inc., a Philippine life insurance company. The new joint venture includes an exclusive bancassurance relationship with the Yuchengco-owned Rizal Commercial Banking Corporation, which serves two million customers in more than 350 branches nationwide.

On November 8, 2011, McLean Budden Limited became the wholly owned subsidiary of MFS Investment Management and added approximately \$30 billion to MFS's assets under management. The combined assets under management of MFS and McLean Budden are C\$261 billion (US\$253 billion). McLean Budden now operates as MFS Investment Management Canada Limited.

In May 2012, the Company entered into an agreement with PVI Holdings to form PVI Sun Life Insurance Company Limited in Vietnam, a joint venture life insurance company, and received its license to operate from the Ministry of Finance of Vietnam in January 2013.

On December 17, 2012, the Company entered into a definitive stock purchase agreement to sell its U.S. annuities business and certain U.S. life insurance businesses (the "U.S. Annuity Business"), including all of the issued and outstanding shares of Sun Life Assurance Company of Canada (U.S.). The U.S. Annuity Business includes domestic U.S. variable annuity, fixed annuity and fixed indexed annuity products, corporate and bank-owned life insurance products and variable life insurance products. The transaction was completed in August 2013.

In January 2013, SLF entered into a strategic partnership with Khazanah Nasional Berhad to acquire 98% of each of CIMB Aviva Assurance Berhad and CIMB Aviva Takaful Berhad (together, "CIMB Aviva") in Malaysia. The transaction was completed in April 2013. As a result, Sun Life Assurance acquired a 49% interest in CIMB Aviva. The names of the CIMB Aviva entities were subsequently changed to Sun Life Malaysia Assurance Berhad and Sun Life Malaysia Takaful Berhad respectively.

In 2014, SLF established Sun Life Investment Management Inc. (SLIM) in Canada. SLIM was created to help Canadian pension funds and other investors seeking additional yield in a low return environment by giving them access to SLF's investments in commercial mortgages, private fixed income and real estate, as well as liability-driven investment (LDI) capabilities.

In April 2015, SLF acquired the New York-based firm Ryan Labs Inc. (Ryan Labs), specializing in liability-driven investment (LDI) and total return fixed income strategies, and adding \$5.1 billion under management and expanding SLF's footprint in the U.S. This purchase is anticipated to build the business overseeing bonds for investors including pension funds and institutional clients.

In July 2015, SLF acquired Prime Advisors, Inc. (Prime), an investment management firm specializing in customized fixed income portfolios, primarily for U.S. insurance companies. As of May 31, 2015, Prime had approximately US\$13 billion in assets under management on behalf of clients.

In September 2015, SLF acquired the Bentall Kennedy group of companies, a real estate investment manager operating in Canada and the U.S., which provides specialized real estate investment management and real estate services, including property management and leasing. At the end of the first quarter 2015, Bentall Kennedy had assets under management of \$27 billion and provided real estate service across 91 million square feet of properties.

## Company History: (Continued...)

In September 2015, SLF announced an agreement with Assurant, Inc. (Assurant) to acquire Assurant's employee benefits business for a net investment of US\$975 million. The transaction will significantly increase the size and scale of the SLF U.S. Group Benefits business, growing business in-force by more than 50%. The transaction closed on March 1, 2016.

In November 2015, the Company announced the acquisition of an additional ownership interest in its Vietnam joint venture, PVI Sun Life Insurance Company Limited, from PVI Holdings, increasing its ownership to 75% from 49%. The transaction closed on January 8, 2016.

In December 2015, SLF announced the acquisition of an additional ownership interest in its India Insurance joint venture, Birla Sun Life Insurance Company Limited, from Aditya Birla Nuvo Limited, increasing its ownership to 49% from 26%. The transaction closed on April 11, 2016.

In March 2016, SLF announced the acquisition of the remaining 51% of PT CIMB Sun Life (CSL), an Indonesian life insurance company, from its long-term partner, CIMB Group. The transaction closed on July 1, 2016 and resulted in SLF owning 100% of CSL. CSL transferred all of its portfolios to PT. Sun Life Financial Indonesia in September 2016 and ceased to be an active life insurance company in December 2016. The name of CSL was subsequently changed to PT. Cakrawala Solusi Lintas.

In August 2016, SLF announced the acquisition of the remaining 25% of PVI Sun Life Insurance Company Limited (PVI Sun Life) from PVI Holdings. The transaction closed on November 9, 2016 and the name of PVI Sun Life was changed to Sun Life Vietnam Insurance Company Limited.

In August 2016, SLF announced that Sun Life Hong Kong Limited (Sun Life HK) would acquire the pension business of FWD Life Insurance Company (Bermuda) Limited (FWD), consisting of the business of Mandatory Provident Fund (MPF) and Occupational Retirement Schemes Ordinance (ORSO). Sun Life HK and FWD also entered into an exclusive 15-year distribution agreement that allows Sun Life HK to distribute its pension products. The first stage of the acquisition that included acquisition of FWD and the 15-year distribution agreement, was closed on October 3, 2017. The name of the acquired entity, FWD Pension Trust Limited, was changed to Sun Life Pension Trust Limited. The completion of the second and final stage of the transaction involves the purchase of the ORSO, and is expected to close by the end of 2018.

In March 2017, SLF announced that Sun Life Vietnam Insurance Company Limited ('Sun Life Vietnam') had entered into a 3-year partnership agreement with Global Online Financial Solutions Limited ("GOFS"), one of the fastest-growing and leading Fintech providers in Vietnam which operates the first digital banking platform in Vietnam under the "Timo" brand. This followed the acquisition in January 2017 by Sun Life Financial of a 25% stake in Crescent Asia Limited, the holding company of GOFS. Under the partnership, Timo will be able to offer life and health insurance products to its members. Moreover, Timo's members will be able to access Sun Life Vietnam's products directly via the bank's mobile application.

In April 2017, the U.S. business group of SLF entered into an agreement to acquire The Premier Dental Group, Inc. (PDG), a Minnesota-based dental network that offered one of the strongest dental preferred provider networks (PPOs) in the state, as well as network offerings in Florida, Wisconsin, Missouri and several other Midwestern states. The transaction was closed on June 1, 2017. Sun Life has become the insurer with the largest PPO dental network in the U.S. with the launch of new proprietary Sun Life Dental Network (that includes PDG dental network), which has approximately 125,000 unique providers.

In September 2017, SLF announced that Sun Life Global Investments (Canada) Inc. and Excel Funds Management Inc. had entered into an agreement whereby Sun Life Global Investments would purchase all of the outstanding shares of both Excel Funds Management Inc. and Excel Investment Counsel Inc., expanding Sun Life's product suite into emerging market funds. The transaction was closed on January 2, 2018.

## Company Operations:

**Licensed Territory:** (Current since 11/26/2001). The company is licensed in all provinces and territories. It is also licensed in the United States in the District of Columbia, Puerto Rico, U.S. Virgin Islands, AL, AK, AZ, AR, CA, CO, CT, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI and WY. Through its subsidiaries and joint ventures, the company also conducts business in the United Kingdom, Ireland, Hong Kong, the Philippines, Indonesia, India, China, Vietnam, Malaysia, Singapore and Bermuda.

## Company Operations: (Continued...)

2017

Rank	Top 5 Lines of Business by NPW	
1	Non-Canadian	36.1%
2	Individual life	28.0%
3	Group A&S	21.6%
4	Group annuities	4.3%
5	Individual A&S	3.8%

Source: Bestlink - Best's Statement File - L/H, Canada

## Company Management:

Last significant update on 07/27/2018

### Officers

**Chairman of the Board:** William D. Anderson**President and CEO:** Dean A. Connor**President:** Claude A. Accum (SLF Asia)**President:** Daniel R. Fishbein (SLF U.S.)**President:** Jacques Goulet (SLF Canada)**President:** Stephen C. Peacher (Sun Life Investment Management)**EVP and CFO:** Kevin D. Strain**EVP and Chief Information Officer:** Mark S. Saunders**EVP and Chief Risk Officer:** Colm J. Freyne**EVP and Chief Legal Officer:** Melissa J. Kennedy (Public Affairs)**EVP and Chief Human Resource Officer:** Carolyn D. Blair (Communications)**EVP:** Kevin P. Dougherty (Innovation and Partnerships)**EVP:** Linda M. Dougherty (Corporate Strategy & Global Marketing)

### Directors

William D. Anderson (Chairman)

Dean A. Connor

Stephanie Coyles

Martin J. G. Glynn

Sara Grootwassink-Lewis

M. Marianne Harris

Christopher J. McCormick

Scott F. Powers

Réal Raymond

Hugh D. Segal

Barbara G. Stymiest

## Regulatory:

**Auditor:** Deloitte LLP

The 2017 annual independent audit of the company was conducted by Deloitte LLP.

A Best's Financial Strength Rating opinion addresses the relative ability of an insurer to meet its ongoing insurance obligations. The ratings are not assigned to specific insurance policies or contracts and do not address any other risk, including, but not limited to, an insurer's claims-payment policies or procedures; the ability of the insurer to dispute or deny claims payment on grounds of misrepresentation or fraud; or any specific liability contractually borne by the policy or contract holder. A Financial Strength Rating is not a recommendation to purchase, hold or terminate any insurance policy, contract or any other financial obligation issued by an insurer, nor does it address the suitability of any particular policy or contract for a specific purpose or purchaser.

A Best's Issue/Issuer Credit Rating is an opinion regarding the relative future credit risk of an entity, a credit commitment or a debt or debt-like security.

Credit risk is the risk that an entity may not meet its contractual, financial obligations as they come due. These credit ratings do not address any other risk, including but not limited to liquidity risk, market value risk or price volatility of rated securities. The rating is not a recommendation to buy, sell or hold any securities, insurance policies, contracts or any other financial obligations, nor does it address the suitability of any particular financial obligation for a specific purpose or purchaser.

In arriving at a rating decision, A.M. Best relies on third-party audited financial data and/or other information provided to it. While this information is believed to be reliable, A.M. Best does not independently verify the accuracy or reliability of the information. Any and all ratings, opinions and information contained herein are provided "as is," without any express or implied warranty.

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Sun Life  
2323 Grand Blvd  
Kansas City MO 64108-2670

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1439 20895

J3D9 [5] 1 of 1



[DM-]

# Explanation of Benefits

## THIS IS NOT A BILL

### Forwarding Service Requested

\*\*\*\*\*SGLP  
PB-STL\_UNSORTED-MACH-ENV 5 1  
JOHN SAMPLE  
ADDRESS 1  
CITY STATE ZIP

### Customer Service Information

Please direct correspondence to:  
SunLife Test Group Name  
2323 GRAND BLVD  
KANSAS CITY, MO 64108  
T 866.362.5955 F 563.242.0184

This is your Sun Life Dental explanation of benefits (EOB). Here you will find a summary of your recent dental claim(s), including the amount your dentist billed us, the amount Sun Life paid your dentist, the amount you may be responsible for, and an update to your annual plan benefits. Please review this summary carefully for accuracy. Have questions about your claim? We're here to help. Please call or email us using our Customer Service contacts noted above.

### YOUR DENTAL CLAIM SUMMARY

<b>Amount billed to Sun Life by your dentist</b> \$287.53	This is the amount your dentist billed us. It may reflect one or more dental procedures.
<b>Amount Sun Life paid your dentist</b> \$146.53	This is the amount Sun Life paid your dentist. It reflects benefits payable under your plan for each procedure. Plan benefits may be subject to an annual deductible and annual maximum.
<b>Your Responsibility</b> \$141.00	This is the amount your dentist may bill you after Sun Life has paid your plan's benefits. This amount may reflect a deductible, your co-pay or coinsurance, or amounts that exceed your policy's annual maximum.

Claim #: 9999999999

Client/Group No.: PC/0000G933

Network: Dental Health Alliance

Patient: SALLY SAMPLE

Provider: ABC DENTAL

Insured: JOHN SAMPLE

Relationship: Spouse

Service Date	Submitted Service Description	Tth No.	Submitted Services	Submitted Charges	Allowed Service	Allowed Amount	Co-Pay %	Deductible	PPO Savings	Patient Resp	Remark Code(s)	Plan Payment
01/29/19	Prefabricated post and core in addition	19	D2954	\$282.00	D2954	\$282.00	50	\$0.00	\$0.00	\$141.00		\$141.00
01/30/19	Unspecified		INTRS	\$5.53	INTRS	\$5.53	0	\$0.00	\$0.00	\$0.00		\$5.53
<b>TOTALS</b>				<b>\$287.53</b>		<b>\$287.53</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$141.00</b>		<b>\$146.53</b>

**Total Patient Responsibility:**

**\$141.00**

Draft/Check	Benefit	COB Amount	Adjustment	Payment	Payee
0040451865	\$146.53	\$0.00	\$0.00	\$146.53	ABC DENTAL



### Understanding your plan's deductible and policy maximum:

Your Plan has a deductible (per plan member) of \$50.00 and will pay up to \$2,500.00 in benefits for each plan period (this typically aligns with your employer's benefits year, but can differ). Here is a summary of where you stand after accounting for this claim.

#### Plan Year Deductible

\$50.00	\$50.00
---------	---------

You have satisfied \$50.00 of your plan's \$50.00 deductible.

#### Plan Year Allowable Maximum

\$310.60	\$2,189.40
----------	------------

You have used \$310.60 of your plan's allowable \$2,500.00 maximum. You have \$2,189.40 plan benefits remaining for this period.

**Thank you for using a dentist in our PPO network. By seeing a network provider, you can feel confident you are in good hands. Regular preventive dental care can make a difference in the overall health of your mouth and body. Don't forget to schedule your next regular checkup!**

If you suspect fraud or abuse, please email us at test.

If the patient is covered by more than one dental (health) benefit plan, all claims should be filed with each plan.

#### Appealing a denial of the dental claim

If you disagree with any part of our decision, you or your authorized representative may ask for an appeal review. You need to fax or mail your appeal to us within two years of receiving this notice. Our contact information is available on the first page of this notice. Please include your name, claim number and date of service.

To assist in the appeal review, you need to explain the reasons why you disagree with our decision. You may also include new information – clinical or otherwise – that supports your dental claim. A Sun Life appeal consultant, not involved in the initial review, will make a decision using all available information.

You have the right to request at no cost:

- Copies of any guidelines we used in making our decision
- An explanation of the clinical review if our initial decision was due to dental necessity, experimental treatment or a similar exclusion
- The identity of any dental experts whose advice we considered
- A copy of your dental claim file

We will make a decision within 60 days of our receipt of the request for appeal review.

If, upon appeal review, your claim is denied, you may have the right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, if your claim is governed by that Act.

We are available to answer questions you may have about your claim.

Insurance products are underwritten by Union Security Insurance Company (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (Wellesley Hills, MA).

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# ARIZONA STATE RETIREMENT SYSTEM

**Stacia Almquist**  
VP, Dental and Vision, SLF US  
Executive Sponsor

**Veronica Lee**  
Sr. Client Relationship Executive

**Cristina Stevens**  
Key Account Service Representative

**April Shaw**  
Sr. Data Operations  
Specialist

**Alexis Evarts**  
Director, Client  
Relationship Services

**Matthew Feran**  
Associate Director, Sr. Client  
Relationship Executives

**Michael Yarbrough**  
Dental Network Manager

**Trina Snowden**  
Manager, Dental Claims

**Craig Bunshaw**  
National Account Consultant

**Jill Johnson**  
Sr. Manager, Resolutions

**Michael Hall**  
Sr. Manager, Dental Networks

**Lindsay Majerus**  
Sr. Manager,  
Dental Claims

**Kimberley Nason**  
Director, National Accounts  
Underwriting

**Greg Meagher**  
Director, Dental Networks  
(Stacia Almquist, VP  
Dental and Vision)

**David Riley**  
AVP, Dental and Vision  
Claims  
(Stacia Almquist, VP  
Dental and Vision)

**Corinne Hanson**  
Associate Director, Quality Improvement  
(Stacia Almquist, VP Dental and Vision)

## ENROLLMENT (Jenn Robbins, Director Field Enrollment)

**Sarah Silberberg**  
Associate Director, Enrollment

**Beth Ann Schuster**  
Benefit Counselor

**Lynn McCarty**  
Benefit Counselor

**Debra Judd**  
ASRS, Temporary  
Assignment

## IMPLEMENTATION (Alexis Evarts, Director Client Relationship Services)

**Jessica O'Donnell**  
Sr. National Account  
Implementation Manager

**Lauren Warnat**  
Sr. National Account  
Implementation Manager



## Arizona State Retirement System Illustrative Implementation Milest

\*\*Based on Sun Life retaining PPO and PPD plans

Implementation & Conversion Planning	
Task	Proposed Timeline
Conduct initial Implementation & Conversion planning meeting with ASRS to review implementation process, timeline and schedule regular implementation calls	April 2020
Review enhancement to network	April 2020
Provide detailed implementation project plan	late April 2020
Enrollment	
Task	Proposed Timeline
Discuss Open Enrollment strategy	Late May 2020 - Early June 2020
3rd Quarter newsletter article with sneak peak of upcoming plan changes and enhancements	May 2020
Open Enrollment materials - lay out timeline for initial proofs, final approvals	July 2020
Open Enrollment call to review strategy, physical locations, meeting details	Early August 2020
Open Enrollment guide drafts & feedback	September 2020
Finalize Open Enrollment meeting location schedule	Mid-September 2020
Inform ASRS of additional online resources for enrollment (temporary job placement)	September 2020
Provide updated video materials, updated welcome kit and updates to microsite materials for the 2021 plan year	Late September 2020
Provide Open Enrollment meeting attendee contact information	October 2020
Confirm temporary employee workstation preparation at ASRS and contracted dates	October 2020
Sun Life/ASRS microsite updated with plan documents for 2021	Late October 2020

Conduct Open Enrollment meetings	November 2020
Validate EDX feed format and timing	November 2020
EDX Open Enrollment file transmission	Early December 2020
<b>Plan Materials</b>	
Task	Proposed Timeline
Confirm final plan designs to be offered	April 2020
Provide draft contracts/certificates for PPO and Evidence of Coverage for Prepaid	August 2020
Finalize draft documents and performance guarantees	Late September 2020 - Early October 2020
Mail ID cards/fulfillment to members	December 2020* *contingent on receipt of EDX Open Enrollment file
<b>Reporting</b>	
Task	Proposed Timeline
Review annual member survey timing, email address file, methodology, questions	June 2020
Review reporting, gather feedback and discuss any adjustments to 2021 reports	Late August 2020
Review Performance Guarantees and desired quarterly/annual reporting	Late August 2020
Review additional surveys requested, timing and methodology	September 2020

# Sun Life

(ASRS)

Jones\*\*

Owners
Sun Life, ASRS (All)
All
Sun Life
Owners
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ASRS
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Sun Life
Sun Life
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Owners
ASRS
Sun Life
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Sun Life
Owners
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All
All

2323 Grand Boulevard  
Kansas City, MO 64108

# SAMPLE FULFILLMENT PACKET FOR PREPAID DENTAL: HERITAGE SECURE WITH SBA (ARIZONA)

800 - G933  
ARIZONA RETIREE  
12345 SUNSHINE DRIVE  
SCOTTSDALE, AZ 85211

G933 0000 0001 NC JPAAAK HERITAGE SECURE WITH SBA AZ 20050601 12/13/2019







Thank you for selecting Sun Life\* for your dental product. We are pleased to provide you with the attached dental identification cards. If you have previously received cards, please replace your current ID cards with the attached cards.

Register today for a Sun Life account at [www.sunlife.com/account](http://www.sunlife.com/account). A Sun Life account provides you with the ability to:

- Download your ID card
- View benefit and claims information
- Find a dentist

### Go Mobile!

Scan the code on the right (or go to [www.sunlife.com/mobileapps](http://www.sunlife.com/mobileapps)) to download our mobile app, **Benefit Tools**, to access many of the same resources as your Sun Life account.



If you have any questions, please call the toll-free number listed on your ID card.

\*Prepaid dental products are provided by United Dental Care of Arizona, Inc., which is affiliated with Sun Life Assurance Company of Canada (Wellesley Hills, MA).

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**Remember to schedule a dental check up for you and your family.**

## Membership Cards



PREPAID PLAN  
HERITAGE SECURE

GROUP ID NUMBER  
G933

ISSUED TO  
ARIZONA STATE  
RETIREMENT SYSTM

\_\_\_\_\_  
MEMBER SIGNATURE



PREPAID PLAN  
HERITAGE SECURE

GROUP ID NUMBER  
G933

ISSUED TO  
ARIZONA STATE  
RETIREMENT SYSTM

\_\_\_\_\_  
MEMBER SIGNATURE



PREPAID PLAN  
HERITAGE SECURE

GROUP ID NUMBER  
G933

ISSUED TO  
ARIZONA STATE  
RETIREMENT SYSTM

\_\_\_\_\_  
MEMBER SIGNATURE



PREPAID PLAN  
HERITAGE SECURE

GROUP ID NUMBER  
G933

ISSUED TO  
ARIZONA STATE  
RETIREMENT SYSTM

\_\_\_\_\_  
MEMBER SIGNATURE

**Dental Plan:** For eligibility information, call 800- 443- 2995. Refer to your Evidence of Coverage for details. Refer to your Copayment Schedule for copayments. Visit our website at [www.sunlife.com/findadentist](http://www.sunlife.com/findadentist).

**Vision Service Plan (VSP):** Present this card to obtain discounts from VSP providers. To locate a provider, call 800- 877- 7195 or visit [www.vsp.com](http://www.vsp.com). This is not insurance.

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**United Dental Care of Arizona, Inc.**  
**2323 Grand Boulevard**  
**Kansas City, MO 64108- 2670**  
**800- 443- 2995**

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**EVIDENCE OF COVERAGE**

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**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:** Bleeding, pain or acute infection requiring Emergency Services.
- 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 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 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.
- 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 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 certain 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:** Agreements initial Plan Year begins on the Effective Date and last 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 the 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 **SPECIALTY 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 20<sup>th</sup> day of a month will be effective on the first day of the next following month. Change requests received after the 20<sup>th</sup> 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. Members 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 appliances was provided as a Plan Benefit, or (b) during that five (5) year period, appliance becomes unusable and can not 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, micrognathis, 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 for 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.

## 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. 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 (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 situation, neither Company nor Plan Provider shall have any liability or obligation for delay or failure to provide dental services.

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

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**United Dental Care of Arizona, Inc.**  
**2323 Grand Boulevard**  
**Kansas City, MO 64108- 2670**  
**800- 443- 2995**

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**SECURE PLAN WITH SPECIALTY BENEFIT COPAYMENT SCHEDULE**

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**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.**

<b>ADA Code</b>	<b>Service Description **</b>	<b>Member Copayment</b>
	<b><u>Appointments</u></b>	
D0120	Periodic oral evaluation (may only be obtained once in any six calendar months)	No Charge
D0140	Limited oral evaluation, problem focused	25.00
D0150	Comprehensive oral evaluation - new or established patient (may only be obtained once in any six calendar months)	No Charge
D0160	Detailed and extensive oral evaluation - problem focused	20.00
D0170	Re- evaluation – limited, problem focused (established patient; not post- operative visit)	20.00
D0180	Comprehensive periodontal evaluation - new or established patient	20.00
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	80.00

<b>ADA Code</b>	<b>Service Description **</b>	<b>Member Copayment</b>
D9440	Office visit - after regularly scheduled office hours	40.00
None	Office visit – during regularly scheduled hours***	10.00
None	Missed appointment without 24- hour notice***	25.00
<b><u>Diagnostic Dentistry</u></b>		
D0210	X- Ray: intraoral - complete series, including bitewings (may only be obtained once in any three calendar years.)	10.00
D0220	X- Ray: intraoral - periapical first film	No Charge
D0230	X- Ray: intraoral - periapical each additional film	No Charge
D0240	X- Ray: intraoral - occlusal film	No Charge
D0250	X- Ray: extraoral - first film	No Charge
D0260	X- Ray: extraoral - each additional film	No Charge
D0270	X- Ray: bitewing - single film	No Charge
D0272	X- Ray: bitewing - two films (may only be obtained once in any six calendar months)	No Charge
D0274	X- Ray: bitewing - four films (may only be obtained once in any six calendar months)	No Charge
D0277	X- Ray: vertical bitewings - 7 to 8 films	No Charge
D0330	X- Ray: panoramic film (may only be obtained once in any three calendar years)	10.00
D0415	Collection of micro- organisms for culture and sensitivity	No Charge
D0425	Caries susceptibility tests	No Charge
D0460	Pulp vitality tests	No Charge
<b><u>Preventive Dentistry</u></b>		
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.)	10.00
D1120	Prophylaxis - child up to age 18 (may only be obtained once in any six calendar months, except for medically necessary more frequent prophylaxis as determined by Member's Plan Dentist)	10.00
D1203	Topical application of fluoride - child up to age 18 (prophylaxis not included)	No Charge
D1310	Nutritional counseling for control of disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth	20.00
D1510	Space maintainer - fixed - unilateral*	85.00
D1515	Space maintainer - fixed - bilateral*	85.00
D1520	Space maintainer - removable - unilateral*	110.00
D1525	Space maintainer - removable - bilateral*	135.00
D1550	Re- cementation of space maintainer	25.00
None	Additional prophylaxis*** (Additional prophylaxis does not apply to patients with periodontal disease)	35.00
D9940	Occlusal guards, by report	95.00
D9951	Occlusal adjustment – limited	55.00
D9952	Occlusal adjustment – complete	280.00
<b><u>Restorative Dentistry</u></b>		
D2140	Amalgam - one surface, primary or permanent	25.00
D2150	Amalgam - two surfaces, primary or permanent	30.00
D2160	Amalgam - three surfaces, primary or permanent	45.00
D2161	Amalgam - four or more surfaces, primary or permanent	55.00
D2330	Resin- based composite - one surface, anterior	50.00
D2331	Resin- based composite - two surfaces, anterior	65.00

ADA Code	Service Description **	Member Copayment
D2332	Resin- based composite - three surfaces, anterior	80.00
D2335	Resin- based composite - four or more surfaces or involving incisal angle (anterior)	110.00
D2391	Resin- based composite - one surface, posterior	85.00
D2392	Resin- based composite - two surfaces, posterior	100.00
D2393	Resin- based composite - three surfaces, posterior	105.00
D2394	Resin- based composite - four or more surfaces, posterior	130.00
D2510	Inlay - metallic - one surface*	245.00
D2520	Inlay - metallic - two surfaces*	275.00
D2530	Inlay - metallic - three or more surfaces*	315.00
D2542	Inlay- metallic - two surfaces*	305.00
D2543	Onlay - metallic - three surfaces*	325.00
D2544	Onlay - metallic - four or more surfaces*	340.00
D2610	Inlay - porcelain/ceramic - one surface*	280.00
D2620	Inlay - porcelain/ceramic - two surfaces*	310.00
D2630	Inlay - porcelain/ceramic - three or more surfaces*	330.00
D2740	Crown - porcelain/ceramic substrate*	295.00
D2750	Crown - porcelain fused to high noble metal*	295.00
D2751	Crown - porcelain to predominantly base metal*	295.00
D2752	Crown - porcelain fused to noble metal*	295.00
D2790	Crown - full cast high noble metal*	295.00
D2791	Crown - full cast predominantly base metal*	295.00
D2792	Crown - full cast noble metal*	295.00
D2910	Recement inlay, onlay or partial coverage restoration	30.00
D2920	Recement crown	30.00
D2930	Prefabricated stainless steel crown - primary tooth	105.00
D2940	Sedative filling	35.00
D2950	Core buildup, including any pins	55.00
D2951	Pin retention - per tooth, in addition to restoration	25.00
D2952	Cast post and core in addition to crown*	135.00
D2954	Prefabricated post and core in addition to crown	105.00
D2962	Labial veneer (porcelain laminate) - laboratory*	330.00
D2980	Crown repair, by report*	30.00
None	Temporary filling***	25.00
<b>Endodontics</b>		
D3110	Pulp cap - direct (excluding final restoration)	25.00
D3120	Pulp cap - indirect (excluding final restoration)	22.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	60.00
D3310	Root canal therapy: anterior (excluding final restoration)	145.00
D3320	Root canal therapy: bicuspid (excluding final restoration)	225.00
D3330	Root canal therapy: molar (excluding final restoration)	295.00
D3346	Retreatment of previous root canal therapy - anterior	335.00
D3347	Retreatment of previous root canal therapy - bicuspid	395.00
D3348	Retreatment of previous root canal therapy - molar	480.00
D3410	Apicoectomy/periradicular surgery - anterior	270.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	300.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	335.00
D3426	Apicoectomy/periradicular surgery (each additional root)	115.00
D3430	Retrograde filling - per root	85.00
D3450	Root amputation - per root	175.00

ADA Code	Service Description **	Member Copayment
D3920	Hemisection (including any root removal), not including root canal therapy	145.00
<b><u>Periodontics</u></b>		
D4210	Gingivectomy or gingivoplasty - 4 + contiguous or bounded teeth spaces per quadrant	175.00
D4211	Gingivectomy or gingivoplasty - 1 to 3 teeth, per quadrant	75.00
D4240	Gingival flap procedure, including root planing – 4 + contiguous or bounded teeth spaces per quadrant	170.00
D4241	Gingival flap procedure including root planning - one to three contiguous teeth or bounded teeth spaces per quadrant	130.00
D4260	Osseous surgery (including flap entry and closure) 4+ contiguous or bounded teeth spaces per quadrant	490.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces, per quadrant	284.00
D4320	Provisional splinting – intracoronal	170.00
D4321	Provisional splinting – extracoronal	150.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	90.00
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	57.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	90.00
D4910	Periodontal maintenance	55.00
None	Periodontal hygiene instructions***	5.00
<b><u>Removable Prosthodontics (Dentures)</u></b>		
D5110	Complete denture - maxillary*	385.00
D5120	Complete denture - mandibular*	385.00
D5130	Immediate denture - maxillary*	480.00
D5140	Immediate denture - mandibular*	480.00
D5211	Maxillary partial denture - resin base*	410.00
D5212	Mandibular partial denture - resin base*	410.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases*	495.00
D5214	Mandibular partial denture - cast metal framework with resin denture base* (D5211 - D5214 includes any conventional clasps, rests, and teeth)	495.00
D5410	Adjust complete denture – maxillary	35.00
D5411	Adjust complete denture – mandibular	35.00
D5421	Adjust partial denture – maxillary	35.00
D5422	Adjust partial denture – mandibular	35.00
D5510	Repair broken complete denture base*	70.00
D5610	Repair resin denture base*	80.00
D5620	Repair cast framework*	80.00
D5630	Repair or replace broken clasps*	100.00
D5640	Repair broken teeth - per tooth*	65.00
D5650	Add tooth to existing partial denture*	90.00
D5730	Reline complete maxillary denture (chairside)	150.00
D5731	Reline complete mandibular denture (chairside)	150.00
D5740	Reline maxillary partial denture (chairside)	140.00
D5741	Reline mandibular partial denture (chairside)	140.00
D5750	Reline complete maxillary denture (laboratory)*	150.00
D5751	Reline complete mandibular denture (laboratory)*	150.00
D5760	Reline maxillary partial denture (laboratory)*	150.00
D5761	Reline mandibular partial denture (laboratory)*	150.00
D5850	Tissue conditioning, maxillary	60.00
D5851	Tissue conditioning, mandibular	60.00

ADA Code	Service Description **	Member Copayment
D5862	Precision attachment, by report*	160.00
<b><u>Fixed Prosthodontics (Bridges or Fixed Partial Dentures)</u></b>		
D6210	Pontic - cast high noble metal*	340.00
D6211	Pontic - cast predominantly base metal*	340.00
D6212	Pontic - cast noble metal*	340.00
D6240	Pontic - porcelain fused to high noble metal*	340.00
D6241	Pontic - porcelain fused to predominantly base metal*	340.00
D6242	Pontic - porcelain fused to noble metal*	340.00
D6251	Pontic - resin with predominantly base metal*	340.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis*	165.00
D6721	Crown - resin with predominantly base metal*	340.00
D6750	Crown - porcelain fused to high noble metal*	340.00
D6751	Crown - porcelain fused to predominantly base metal*	340.00
D6752	Crown - porcelain fused to noble metal*	340.00
D6780	Crown - 3/4 cast high noble metal*	340.00
D6790	Crown - full cast high noble metal*	340.00
D6791	Crown - full cast predominantly base metal*	340.00
D6792	Crown - full cast noble metal*	340.00
D6930	Recement fixed partial denture	55.00
D6940	Stress breaker	150.00
D6950	Precision attachment, by report	230.00
D6980	Fixed partial denture repair, by report*	55.00
None	Resin bonded bridge pontic, per unit***(*)	245.00
<b><u>Oral Surgery</u></b>		
D7111	Extraction, coronal remnants – deciduous tooth	25.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	25.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	85.00
D7220	Removal of impacted tooth - soft tissue	105.00
D7230	Removal of impacted tooth - partially bony	140.00
D7240	Removal of impacted tooth – completely bony	165.00
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	205.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	85.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	175.00
D7280	Surgical access of an unerupted tooth	165.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant	95.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	140.00
D7510	Incision and drainage of abscess – intraoral soft tissue	95.00
D7960	Frenulectomy (frenectomy or frenotomy) separate procedure	205.00
<b><u>Bleaching</u></b>		
D9972	External Bleaching per arch	185.00
<b><u>Anesthesia, Analgesia, and Sedation</u></b>		
D9220	Deep sedation/general anesthesia – first 30 minutes	185.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide - per 30 minutes	20.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	180.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	40.00



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

If Member requires dental specialty services that cannot be provided by selected Plan Dentist, Member may obtain such services from an SBA Plan Specialist or Non-SBA Plan Specialist. No referral from Member's selected Plan Dentist is needed. However, Member's out-of-pocket expenses may vary depending on whether services are received from an 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 specified types of specialty services from an 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 an 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.

<b>ADA Codes</b>	<b>Service Description</b>	<b>Member Copayment</b>
D0140	Limited oral evaluation, problem focused	35.00
D0150	Comprehensive oral evaluation - new or established patient	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
D3320	Root canal therapy: bicuspid (excluding final restoration)	280.00
D3330	Root canal therapy: molar (excluding final restoration)	395.00
D3346	Retreatment of previous root canal therapy - anterior	360.00
D3347	Retreatment of previous root canal therapy - bicuspid	525.00
D3348	Retreatment of previous root canal therapy - molar	545.00
D3410	Apicoectomy/periradicular surgery - anterior	265.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	280.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	310.00
D3430	Retrograde filling, per root	90.00
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	335.00
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	100.00
D4260	Osseous Surgery (including flap entry and closure) Four + teeth per quadrant	495.00
D4261	Osseous Surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces, per quadrant	215.00
D4341	Periodontal scaling and root planning - four or more teeth per quadrant	100.00
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	70.00

ADA Codes	Service Description	Member Copayment
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	80.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	50.00
D7210	Surgical removal of erupted tooth	80.00
D7220	Removal of impacted tooth - soft tissue	105.00
D7230	Removal of impacted tooth - partial bony	135.00
D7240	Removal of impacted tooth - complete bony	200.00
D7241	Removal of impacted tooth - complete bony with complications	220.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	75.00
D7310	Alveoloplasty in conjunction with extractions, per quadrant	180.00
D7320	Alveoloplasty not in conjunction with extractions, per quadrant	130.00
D7510	Incision and drainage of abscess, intraoral soft tissue	105.00
D7960	Frenulectomy (frenectomy or frenotomy) separate procedure	185.00
D9241	Intravenous 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 will be responsible for paying the entire reduced charge either at the time the service is received, or in accordance with Plan Specialist's billing procedures.

*\*\*Current Dental Terminology (c) American Dental Association. All Rights Reserved.*

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

## **United Dental Care of Arizona, Inc.**

### **MEMBER RIGHTS AND RESPONSIBILITIES**

#### **Member Rights**

- Receive an appointment for an initial visit within six weeks of being assigned to a provider.
- Receive an emergency visit within 24 hours of the onset of the dental emergency as verified by United Dental Care of Arizona, Inc.
- Be treated with respect and receive recognition of their dignity and need for privacy by dental health care providers and their staff and employees of United Dental Care of Arizona, Inc.
- Participate in the decision making process regarding the dental health care and treatment.
- Be provided with complete and up to date information on United Dental Care of Arizona, Inc., the dental health care provider network and member rights and responsibilities.
- Ask questions or request assistance from United Dental Care of Arizona, Inc. when using their dental benefit plan.
- Voice grievances about United Dental Care of Arizona, Inc. or a contracted dental health care provider and receive a timely response.

#### **Member Responsibilities**

- Treat dental health care providers and their staffs and United Dental Care of Arizona, Inc. employees with respect.
- Cooperate and comply with the instructions of those providing the member's dental treatment.
- Be aware of the features of their dental benefit plan, plan limitations and exclusions and the dental provider network.
- Engage in the home oral health care practices recommended by their dental health care providers.
- Select a family dentist from the United Dental Care of Arizona, Inc. list of providers in a timely fashion.
- Provide advance notice to the dental office of appointment cancellation.
- Fully disclose medial history to dental health providers upon request.

## HIPAA Notice of Privacy Practices

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

This Notice applies to our HIPAA covered dental and vision plans.

### Our Commitment

Union Security Insurance Company, Union Security Life Insurance Company of New York, and the prepaid dental companies\* are committed to protecting the personal information entrusted to us by our customers. The trust you place in us when you share your personal information is a responsibility we take very seriously and is the cornerstone of how we conduct our business.

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

### Our Use and Disclosure of Your PHI

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

Other examples of possible disclosures for purposes of healthcare operations include:

- Underwriting our risk and determining rates and premiums for your healthcare plan;
- Determining your eligibility for benefits;
- Reviewing the competence and qualifications of healthcare providers;
- Conducting or arranging for review, legal services, and auditing functions, including fraud and abuse detection and compliance;
- Business planning and development;

- Business management and general administrative duties such as cost-management, customer service, and resolution of internal grievances;
- Other administrative purposes.
- We can also make disclosures under the following circumstances without your permission:
- As required by law, including response to court and administrative orders, or to report information about suspected criminal activity;
- To report abuse, neglect, or domestic violence;
- To authorities that monitor our compliance with these privacy requirements;
- To coroners, medical examiners, and funeral directors;
- For research and public health activities, such as disease and vital statistic reporting;
- To avert a serious threat to health or safety;
- To the military, certain federal officials for national security activities, and to correctional institutions;
- To the entity sponsoring your group healthcare plan but only for purposes of enrollment, disenrollment, eligibility or for the purpose of giving the plan sponsor summary information when necessary to help make decisions regarding changes to the plan. If the plan sponsor has certified that its plan documents have been amended to include certain privacy provisions, we may also disclose protected health information to the plan sponsor to carry out plan administration functions that the plan sponsor performs on behalf of the plan;
- To a spouse, family member, or other personal representative if they can show they are assisting in your care or payment of your care and then, without an authorization, only basic information about the status or payment of a claim.

**Unless you give us written authorization, we cannot use or disclose your PHI for any reason except as otherwise described in this notice**, including uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute the sale of protected health information. We are prohibited from using or disclosing your protected health

Insurance products are underwritten by Union Security Insurance Company (USIC) (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (SLOC) (Wellesley Hills, MA) in all states except New York. Prepaid dental products are provided by USIC and are administered by SLOC, and are provided by prepaid dental companies affiliated with SLOC in certain states except New York. Prepaid dental companies are Denticare of Alabama, Inc., United Dental Care of Arizona, Inc., UDC Dental California, Inc., United Dental Care of Colorado, Inc., Union Security DentalCare of Georgia, Inc., United Dental Care of Michigan, Inc., United Dental Care of Missouri, Inc., Union Security DentalCare of New Jersey, Inc., United Dental Care of New Mexico, Inc., UDC Ohio, Inc., United Dental Care of Texas, Inc., and United Dental Care of Utah, Inc. In New York, insurance products and prepaid dental products are underwritten or provided by Union Security Life Insurance Company of New York (Fayetteville, NY) and administered by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).

information that is genetic information for underwriting purposes. You may revoke your written authorization at any time by writing us at the address indicated at the end of this notice.

### **Your Individual Rights**

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

- **To Restrict our Use or Disclosure.** You have the right to ask us to limit our use or disclosure of your PHI. While we will consider your request, we are not legally required to agree to the additional restrictions. If we do agree to all or part of your request, we will inform you in writing. We cannot agree to limit any use and disclosure of your PHI if the use or disclosure is required by law.
- **To Access your PHI.** You have the right to view and/or copy your PHI at any time by contacting us. If you want copies of your PHI, or want your PHI in a special format, we may charge you a fee. You have a right to choose what portions of your PHI you want copied and to have prior notice of copying costs. If for some reason we deny your request for access to your PHI, we will provide a written explanation of why your request was denied and explain how you can appeal the denial.
- **To Amend your PHI.** You have the right to amend your PHI, if you believe it is incomplete or inaccurate. Your request must be in writing, with an explanation of why you feel the information should be amended. If we approve your request to amend your PHI, we will make reasonable efforts to inform others, including people you name, about the amendment to your PHI. We may deny your request for various reasons, for example, if we determine that the information is correct and complete, or if we did not create the information. If we deny your request, we will provide you a written explanation of our decision. We also will explain your rights regarding having your request and our response included with all future disclosures of your PHI.
- **To Obtain an Accounting of our Disclosures.** You have the right to receive a listing from us of all instances in the past six years in which we or our business associates have disclosed your PHI for purposes other than treatment, payment, health care operations, or as authorized by you. The accounting will tell you the date we made the disclosure, the name of the person or entity to whom the disclosure was made, a description of the PHI that was disclosed, and the reason for the disclosure. There may be a charge for accounting disclosures if requested more than once a year.
- **To Request Alternative Communications.** You have the right to ask us to communicate with you about your confidential information by a different method or at another location. We will accommodate all reasonable requests.
- **To Be Notified of a Breach:** You will be notified in the event that unsecured protected health information is compromised.
- **To Receive Notice.** You are entitled to receive a copy of this notice that outlines our HIPAA privacy practices. We reserve the right to change these

practices and the terms of this notice at any time. We will not make any material changes to our privacy practices without first sending you a revised notice. If you receive this notice on our web site or by electronic mail, you may request a paper copy.

### **Who to Contact for Questions and Complaints**

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

**Mailing Address:** Sun Life Financial  
Privacy Officer  
P.O. Box 419052  
Kansas City, MO 64141-6052

**Telephone:** 800.733.7879

**Email:** SLF\_US\_Privacy@sunlife.com

**Web Site:** [www.sunlife.com/us](http://www.sunlife.com/us)

### **For New York business:**

**Mailing Address:** Union Security Life Insurance  
Company of New York  
Privacy Officer  
Administered by:  
Sun Life Financial  
P.O. Box 419052  
Kansas City, MO 64141-6052

**Telephone:** 888.901.6377

**Email:** SLF\_US\_Privacy@sunlife.com

### **Organizations Covered by This Notice**

This notice applies to the privacy practices of the organizations referenced below. These organizations may share your PHI with each other as needed for payment activities or health care operations relating to the healthcare plans that we provide.

**Effective Date of This Notice:** April 14, 2003.

**Revised:** October 21, 2016

\* In this notice, "we," "us," and "our" refer to Union Security Insurance Company, Union Security Life Insurance Company of New York and the following prepaid dental companies: DentiCare of Alabama, Inc., Union Security DentalCare of Georgia, 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., Union Security DentalCare of New Jersey, 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 Department of Insurance and Financial Institutions ("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 and Financial Institutions, Consumer Affairs Division, 100 N. 15th Avenue, Suite 102, Phoenix, AZ 85007-2624.

### **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)

Level 1 Expedited Dental Review

Level 2 Expedited Appeal

Level 3 Expedited External Independent  
Dental Review

#### **Standard Appeals**

(for non- urgent services or denied  
claims)

Informal Reconsideration<sup>1</sup>

Formal Appeal

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.

<sup>1</sup> An informal reconsideration is not available for a denied claim.

<p align="center"><b>EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED</b></p>
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#### **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 of Insurance and Financial Institutions, 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 Department of Insurance and Financial Institutions 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 72 hours 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 4 months 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 4 months 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 4 months 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 Department and Financial Institutions, 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 Department of Insurance and Financial Institutions 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 Arizona Department of Insurance and Financial Institutions 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 Arizona Department of Insurance and Financial Institutions 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 \_\_\_\_\_

**SAMPLE FULFILLMENT PACKET FOR PREPAID  
DENTAL: DHMO 220 WITH ORTHODONTIA  
(ARIZONA)**

2323 Grand Boulevard  
Kansas City, MO 64108

801 - G933  
ARIZONA RETIREE  
100 MAIN ST  
TUCSON, AZ 85711

G933 0000 0020 E6 FNAE7B DHMO 220 W/ORTHO AZ 20200101 12/13/2019







Thank you for selecting Sun Life\* for your dental product. We are pleased to provide you with the attached dental identification cards. If you have previously received cards, please replace your current ID cards with the attached cards.

Register today for a Sun Life account at [www.sunlife.com/account](http://www.sunlife.com/account). A Sun Life account provides you with the ability to:

- Download your ID card
- View benefit and claims information
- Find a dentist

### Go Mobile!

Scan the code on the right (or go to [www.sunlife.com/mobileapps](http://www.sunlife.com/mobileapps)) to download our mobile app, **Benefit Tools**, to access many of the same resources as your Sun Life account.



If you have any questions, please call the toll-free number listed on your ID card.

\*Prepaid dental products are provided by United Dental Care of Arizona, Inc., which is affiliated with Sun Life Assurance Company of Canada (Wellesley Hills, MA).

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**Remember to schedule a dental check up for you and your family.**

## Membership Cards



PREPAID PLAN  
DHMO 220 W/ORTHO

GROUP ID NUMBER  
G933

ISSUED TO  
ARIZONA STATE  
RETIREMENT SYSTEM

\_\_\_\_\_  
MEMBER SIGNATURE



PREPAID PLAN  
DHMO 220 W/ORTHO

GROUP ID NUMBER  
G933

ISSUED TO  
ARIZONA STATE  
RETIREMENT SYSTEM

\_\_\_\_\_  
MEMBER SIGNATURE



PREPAID PLAN  
DHMO 220 W/ORTHO

GROUP ID NUMBER  
G933

ISSUED TO  
ARIZONA STATE  
RETIREMENT SYSTEM

\_\_\_\_\_  
MEMBER SIGNATURE



PREPAID PLAN  
DHMO 220 W/ORTHO

GROUP ID NUMBER  
G933

ISSUED TO  
ARIZONA STATE  
RETIREMENT SYSTEM

\_\_\_\_\_  
MEMBER SIGNATURE

**Dental Plan:** For eligibility information, call 800- 443- 2995. Refer to your Evidence of Coverage for details. Refer to your Copayment Schedule for copayments. Visit our website at [www.sunlife.com/findadentist](http://www.sunlife.com/findadentist).

**Vision Service Plan (VSP):** Present this card to obtain discounts from VSP providers. To locate a provider, call 800- 877- 7195 or visit [www.vsp.com](http://www.vsp.com). This is not insurance.

Prepaid dental products are provided by United Dental Care of Arizona, Inc., which is affiliated with Sun Life Assurance Company of Canada (Wellesley Hills, MA).

**Dental Plan:** For eligibility information, call 800- 443- 2995. Refer to your Evidence of Coverage for details. Refer to your Copayment Schedule for copayments. Visit our website at [www.sunlife.com/findadentist](http://www.sunlife.com/findadentist).

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Prepaid dental products are provided by United Dental Care of Arizona, Inc., which is affiliated with Sun Life Assurance Company of Canada (Wellesley Hills, MA).

**United Dental Care of Arizona, Inc.**  
**8655 E. Via De Ventura**  
**Suite G360**  
**Scottsdale, AZ 85258**  
**602.308.0230/800.233.0881**

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**EVIDENCE OF COVERAGE**

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**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 Emergency Services.
- 1.6 **Dependent:** Subscriber's spouse or domestic partner 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 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 intended to evaluate and stabilize a dental condition of recent onset, control bleeding, and relieve pain. This includes the provision of local anesthesia, and elimination of acute infection, but does not mean a medication that is prescribed by the dentist.
- 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 Specialty Dentist:** A dentist practicing in a dental specialty who is not a Plan Specialty Dentist.
- 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 Specialty Dentist 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 Specialty Dentist. 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 Specialty Dentist:** 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.
- In order to fully understand payment responsibility for dental specialty services, Member should discuss the proposed treatment and its cost with Plan Specialty Dentist prior to receiving treatment. Availability of specific types of specialty services from Plan Specialty Dentists depends on which types of dentists are Plan Specialty Dentists. Company cannot guarantee the availability of any specific type of dentist will be a Plan Specialty Dentist. Types of dentists who are Plan Specialty Dentists may vary from time to time in different parts of the Service Area. Copayments listed in the **PLAN DENTIST SERVICES** Section of the Copayment Schedule that are marked as dental specialty services (S) and in the **ORTHODONTIA SERVICES** Section of the Copayment Schedule apply only to Plan Specialty Dentists who perform the corresponding services listed in the Copayment Schedule. The Plan Specialty Dentist 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 **Prior Plan:** The Group's plan of group dental coverage that was replaced by this Plan.
- 1.21 **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.
- 1.22 **Subscriber:** Shall mean an employee, member or beneficiary of Group who is eligible to participate in Plan under the eligibility requirements determined by Group.

**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.
- 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 **NON-PLAN SPECIALTY DENTIST 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 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 **NON-PLAN SPECIALTY DENTIST SERVICES** Section of the Copayment Schedule.
- 4.5 **Selection of Provider:**
- A **Plan Dentist:** Each Member shall select 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 20<sup>th</sup> day of a month will be effective on the first day of the next following month. Change requests received after the 20<sup>th</sup> 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 Specialty Dentist: If Member requires specialist services that cannot be provided by Member's selected Plan Dentist, Member may obtain services from a Plan Specialty Dentist. 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 a Plan Specialty Dentist or a Non-Plan Specialty Dentist.

- 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 from 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 part of any dental service for which a charge is incurred before the effective date of Member's enrollment for Plan Benefits. This exclusion means only that payment of the incurred charge, at the provider's entire normal retail cost for that part of that service, remains the Member's responsibility after the Member enrolls for Plan Benefits.
  - C Any dental service initiated (a) before the effective date of Member's enrollment for Plan Benefits (except as provided in the **ORTHODONTIC TREATMENT** article of the Evidence of Coverage) or (b) after Member's enrollment for Plan Benefits ends.
  - D Services provided by Non-Plan Providers unless (a) for services of Non-Plan Specialty Dentists as specifically provided in the **NON-PLAN SPECIALTY DENTISTS SERVICES** Section of the Copayment Schedule or (b) for Emergency Services as specifically provided in the **EMERGENCY SERVICES** Article of the Evidence of Coverage.
  - E 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.
  - F Replacement of dentures or other removable appliances due to (a) damage while not in use

- or (b) loss or theft.
- G 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).
- H Replacement of any tooth that has previously been replaced by an implant.
- I Replacement of a tooth by an endosteal implant after a twenty four (24) month period has elapsed since the loss of the tooth.
- J Implants or any related implant appliances (except as provided in the Copayment Schedule), or surgery for the insertion of implants or any related implant appliances, whether fixed or removable.
- K 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.
- L Restorations or splints used to increase vertical dimension, restore occlusion, or replace or stabilize tooth structure lost by attrition.
- M Orthodontic treatment involving therapy for myofunctional problems, TMJ (temporomandibular joint) dysfunctions, micrognathia, macroglossia, cleft palate or other growth and developmental abnormalities
- N Orthodontic treatment associated with orthognathic surgery, whether the treatment precedes or follows the surgery.
- O 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.
- P 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 **Orthodontic Treatment:** If Member was covered under Group's Prior Plan on the day before the Group's Prior Plan was replaced by this Plan, we will provide a pro-rated orthodontic benefit subject to the following conditions:

- A. Orthodontic treatment must already be in progress on the effective date of this Agreement;
- B. Service must be listed under **ORTHODONTIA SERVICES** Section of the Copayment Schedule;
- C. Dentist providing orthodontic treatment under the Prior Plan must have been under contract with Company when providing treatment; and
- D. Member must be less than 24-months into orthodontic treatment.

The pro-rated benefit will be based on the amount of time remaining on Member's 24-month course of orthodontic treatment. The pro-rated benefit will be provided to Plan Provider, and Plan Provider will subtract the pro-rated benefit from Member's balance.

5.5 **Services of Non-Plan Specialty Dentists:** Plan Benefit payments for services of Non-Plan Specialty Dentists, as provided in the **NON-PLAN SPECIALTY DENTIST 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. 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 Specialty Dentist services as specifically stated in the **NON-PLAN SPECIALTY DENTIST 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 Packet.

## 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 the 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 to Group. 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. 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 situation, neither Company nor Plan Provider shall have any liability or obligation for delay or failure to provide dental services.

**TO CONTACT CUSTOMER SERVICE, CALL 800.443.2995**

United Dental Care of Arizona,  
Inc.  
8655 E. Via De Ventura  
Suite G360  
Scottsdale, AZ 85258  
800.233.0881

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## DHMO DENTAL SERIES 220 PLAN COPAYMENT SCHEDULE

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### SECTION I: PLAN DENTIST SERVICES

(Subject to Exclusions and Limitations 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. If Member requires dental specialty services that cannot be provided by selected Plan Dentist, Member may obtain from a Plan Specialty Dentist the services marked as dental specialty services (S) in this Section I. No referral from Member's selected Plan Dentist is needed to receive services from a Plan Specialty 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. 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 actual cost passed on to the member, not to exceed the maximum allowable fee per this plan.

Dental services obtained from a Plan Specialty Dentist that are not listed and marked as dental specialty services (S) in this Section I below will be provided to Member at reduced charges. A 15% reduction from that Plan Specialty Dentist's normal retail charges applies to services obtained from a Plan Specialty Dentist whose practice is limited to endodontics. A 25% reduction from that Plan Specialty Dentist's normal retail charges applies to services obtained from any other Plan Specialty Dentist (including, but not limited to, a Plan Specialty Dentist whose practice is orthodontics). Member is responsible for paying the entire reduced charge either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures.

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.

Any Plan Provider may (but is not required to) charge any Member for any missed appointment, in accordance with the Plan Provider's guidelines, if Member fails to notify the Plan Provider at least 24 hours before the scheduled appointment time. However, the charge to the Member may not exceed \$25.00 per missed appointment.

**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 and for certain Non-Plan Specialty Dentist services as specifically stated in the NON-PLAN SPECIALTY DENTIST SERVICES section of the Copayment Schedule.**

ADA Code**	Service Description**	Member Copayment
<b>Appointments</b>		
None	Office visit - during regularly scheduled hours***	No Charge
D0120	Periodic oral evaluation - established patient (ADA Code D0120 may only be obtained once in any six calendar months, except for medically necessary more frequent evaluations as determined by Member's Plan Dentist.) <sup>†</sup>	No Charge
D0140	Limited oral evaluation - problem focused	No Charge
D0150	Comprehensive oral evaluation - new or established patient (ADA Code D0150 may only be obtained once in any six calendar months, except for medically necessary more frequent evaluations as determined by Member's Plan Dentist.) <sup>†</sup>	No Charge
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Charge
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Charge
D0180	Comprehensive periodontal evaluation - new or established patient	No Charge
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	55.00
D9440	Office visit - after regularly scheduled hours	25.00
<b>Diagnostic Dentistry</b>		
D0210	Intraoral - complete series (including bitewings) (ADA Code D0210 may only be obtained once in any three calendar years, except for medically necessary more frequent x-rays as determined by Member's Plan Dentist.) <sup>†</sup>	No Charge
D0220	Intraoral - periapical first film	No Charge
D0230	Intraoral - periapical each additional film	No Charge
D0240	Intraoral - occlusal film	No Charge
D0250	Extraoral - first film	No Charge
D0260	Extraoral - each additional film	No Charge
D0270	Bitewing - single film	No Charge
D0272	Bitewings - two films (ADA Code D0272 may only be obtained once in any six calendar months, except for medically necessary more frequent x-rays as determined by Member's Plan Dentist.) <sup>†</sup>	No Charge
D0273	Bitewings - three films (ADA Code D0273 may only be obtained once in any six calendar months, except for medically necessary more frequent x-rays as determined by Member's Plan Dentist.)	No Charge
D0274	Bitewings - four films (ADA Code D0274 may only be obtained once in any six calendar months, except for medically necessary more frequent x-rays as determined by Member's Plan Dentist.) <sup>†</sup>	No Charge
D0277	Vertical bitewings - 7 to 8 films	No Charge
D0290	Posterior - anterior or lateral skull and facial bone survey film (ADA code D0290 may only be obtained once in any three calendar years, except for medically necessary more frequent x-rays as determined by Member's Plan Dentist.)	No Charge
D0330	Panoramic film (ADA Code D0330 may only be obtained once in any three calendar years, except for medically necessary more frequent x-rays as determined by Member's Plan Dentist.) <sup>†</sup>	No Charge
D0350	Oral/facial photographic images (ADA Code D0350 may only be obtained once in any three calendar years, except for medically necessary more frequent images as determined by Member's Plan Dentist.)	No Charge
D0415	Collection of microorganisms for culture and sensitivity	No Charge
D0416	Viral Culture (ADA Code D0416 may only be obtained once in any calendar year, except for medically necessary more frequent cultures as determined by Member's Plan Dentist.)	No Charge

ADA Code**	Service Description**	Member Copayment
D0418	Analysis of Saliva Sample (ADA Code D0418 may only be obtained once in any calendar year, except for medically necessary more frequent cultures as determined by Member's Plan Dentist.)	No Charge
D0425	Caries susceptibility tests	No Charge
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	50.00
D0460	Pulp vitality tests	No Charge
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report (ADA Code D0486 may only be obtained once in any six calendar months, except for medically necessary more frequent images as determined by Member's Plan Dentist.)	No Charge
<b>Preventive Dentistry</b>		
D1110	Prophylaxis - adult (ADA Code D1110 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
D1120	Prophylaxis - child (ADA Code D1120 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
D1203	Topical application of fluoride - child	No Charge
D1204	Topical application of fluoride - adult	No Charge
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth	No Charge
D1510	Space maintainer - fixed - unilateral*	50.00
D1515	Space maintainer - fixed - bilateral*	50.00
D1520	Space maintainer - removable - unilateral*	65.00
D1525	Space maintainer - removable - bilateral*	90.00
D1550	Re-cementation of space maintainer	10.00
D1555	Removal of fixed space maintainers	10.00
None	Additional prophylaxis***	35.00
D9940	Occlusal guard, by report*	85.00
D9951	Occlusal adjustment - limited	15.00
D9952	Occlusal adjustment - complete	55.00
<b>Restorative Dentistry</b>		
D2140	Amalgam - one surface, primary or permanent	10.00
D2150	Amalgam - two surfaces, primary or permanent	15.00
D2160	Amalgam - three surfaces, primary or permanent	20.00
D2161	Amalgam - four or more surfaces, primary or permanent	30.00
D2330	Resin-based composite - one surface, anterior	25.00
D2331	Resin-based composite - two surfaces, anterior	35.00
D2332	Resin-based composite - three surfaces, anterior	45.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	70.00
D2390	Resin-based composite crown, anterior	70.00
D2391	Resin-based composite - one surface, posterior	55.00
D2392	Resin-based composite - two surfaces, posterior	65.00
D2393	Resin-based composite - three surfaces, posterior	75.00
D2394	Resin-based composite - four or more surfaces, posterior	95.00
D2510	Inlay - metallic - one surface*	75.00

ADA Code**	Service Description**	Member Copayment
D2520	Inlay - metallic - two surfaces*	85.00
D2530	Inlay - metallic - three or more surfaces*	110.00
D2542	Onlay - metallic - two surfaces*	100.00
D2543	Onlay - metallic - three surfaces*	120.00
D2544	Onlay - metallic - four or more surfaces*	130.00
D2610	Inlay - porcelain/ceramic one surface*	200.00
D2620	Inlay - porcelain/ceramic two surfaces*	210.00
D2630	Inlay - porcelain/ceramic three or more surfaces*	220.00
D2740	Crown - porcelain/ceramic substrate*	220.00
D2750	Crown - porcelain fused to high noble metal*	220.00
D2751	Crown - porcelain fused to predominantly base metal*	220.00
D2752	Crown - porcelain fused to noble metal*	220.00
D2790	Crown - full cast high noble metal*	220.00
D2791	Crown - full cast predominantly base metal*	220.00
D2792	Crown - full cast noble metal*	220.00
D2910	Recement inlay, onlay, or partial coverage restoration	15.00
D2920	Recement crown	15.00
D2930	Prefabricated stainless steel crown - primary tooth	80.00
D2931	Prefabricated stainless steel crown - permanent tooth	90.00
D2932	Prefabricated resin crown	35.00
D2933	Prefabricated stainless steel crown with resin window	45.00
D2940	Sedative filling	15.00
D2950	Core buildup, including any pins	75.00
D2951	Pin retention - per tooth, in addition to restoration	15.00
D2952	Post and core in addition to crown, indirectly fabricated*	90.00
D2953	Each additional indirectly fabricated post - same tooth*	45.00
D2954	Prefabricated post and core in addition to crown	80.00
D2955	Post removal (not in conjunction with endodontic therapy)	25.00
D2957	Each additional prefabricated post - same tooth	30.00
D2971	Additional procedures to construct new crown under existing partial denture framework*	75.00
D2980	Crown repair, by report*	25.00
None	Temporary filling***	15.00
<b>Endodontics</b>		
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
D3221	Pulpal debridement, primary and permanent teeth	55.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	45.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50.00
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	95.00
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)(S)	220.00
D3330	Endodontic therapy, molar (excluding final restoration)(S)	275.00
D3331	Treatment of root canal obstruction, non-surgical access	70.00
D3332	Incomplete endodontic therapy, inoperable, unrestorable or fractured tooth	150.00
D3333	Internal root repair of perforation defects	100.00
D3346	Retreatment of previous root canal therapy - anterior(S)	300.00
D3347	Retreatment of previous root canal therapy - bicuspid(S)	390.00

ADA Code**	Service Description**	Member Copayment
D3348	Retreatment of previous root canal therapy - molar(S)	490.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	175.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	175.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	175.00
D3410	Apicoectomy/periradicular surgery - anterior(S)	125.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)(S)	165.00
D3425	Apicoectomy/periradicular surgery - molar (first root)(S)	275.00
D3426	Apicoectomy/periradicular surgery - (each additional root)	100.00
D3430	Retrograde filling - per root(S)	75.00
D3450	Root amputation - per root	70.00
D3470	Intentional reimplantation (including necessary splinting)	95.00
D3910	Surgical procedure for isolation of tooth with rubber dam	10.00
D3920	Hemisection (including any root removal), not including root canal therapy	80.00
D3950	Canal preparation and fitting of performed dowel or post	65.00
<b>Periodontics</b>		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant(S)	145.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant(S)	85.00
D4230	Anatomical crown exposure - four or more contiguous teeth per quadrant	65.00
D4231	Anatomical crown exposure - one to three teeth per quadrant	55.00
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
D4245	Apically positioned flap	145.00
D4249	Clinical crown lengthening - hard tissue	120.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant(S)	85.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant(S)	60.00
D4263	Bone replacement graft - first site in quadrant*	160.00
D4264	Bone replacement graft - each additional site in quadrant*	145.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration*	80.00
D4266	Guided tissue regeneration - resorbable barrier, per site*	230.00
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	240.00
D4268	Surgical revision procedure, per tooth	90.00
D4270	Pedicle soft tissue graft procedure	265.00
D4271	Free soft tissue graft procedure (including donor site surgery)	260.00
D4273	Subepithelial connective tissue graft procedures, per tooth	75.00
D4275	Soft tissue allograft	320.00
D4320	Provisional splinting - intracoronal	80.00
D4321	Provisional splinting - extracoronal	75.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant(S)	75.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant(S)	35.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis(S)	50.00

ADA Code**	Service Description**	Member Copayment
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report*	40.00
D4910	Periodontal maintenance (limit 2 per calendar year)	45.00
	<b>Removable Prosthodontics (Removable Dentures)</b>	
D5110	Complete denture - maxillary*	295.00
D5120	Complete denture - mandibular*	295.00
D5130	Immediate denture - maxillary*	390.00
D5140	Immediate denture - mandibular*	390.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)*	355.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)*	335.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	365.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	365.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)*	400.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)*	450.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)*	300.00
D5410	Adjust complete denture - maxillary	15.00
D5411	Adjust complete denture - mandibular	15.00
D5421	Adjust partial denture - maxillary	15.00
D5422	Adjust partial denture - mandibular	15.00
D5510	Repair broken complete denture base*	30.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	15.00
D5610	Repair resin denture base*	35.00
D5620	Repair cast framework*	35.00
D5630	Repair or replace broken clasp*	35.00
D5640	Replace broken teeth - per tooth*	35.00
D5650	Add tooth to existing partial denture*	35.00
D5660	Add clasp to existing partial denture*	55.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)*	165.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)*	165.00
D5710	Rebase complete maxillary denture*	195.00
D5711	Rebase complete mandibular denture*	180.00
D5720	Rebase maxillary partial denture*	150.00
D5721	Rebase mandibular partial denture*	155.00
D5730	Reline complete maxillary denture (chairside)	60.00
D5731	Reline complete mandibular denture (chairside)	60.00
D5740	Reline maxillary partial denture (chairside)	60.00
D5741	Reline mandibular partial denture (chairside)	60.00
D5750	Reline complete maxillary denture (laboratory)*	95.00
D5751	Reline complete mandibular denture (laboratory)*	95.00
D5760	Reline maxillary partial denture (laboratory)*	95.00
D5761	Reline mandibular partial denture (laboratory)*	95.00
D5810	Interim complete denture (maxillary)*	240.00
D5811	Interim complete denture (mandibular)*	240.00
D5820	Interim partial denture (maxillary)*	300.00
D5821	Interim partial denture (mandibular)*	300.00
D5850	Tissue conditioning, maxillary	25.00



ADA Code**	Service Description**	Member Copayment
D5851	Tissue conditioning, mandibular	25.00
D5862	Precision attachment, by report*	145.00
D5875	Modification of removable prosthesis following implant surgery	225.00
	<b>Fixed Prosthodontics (Bridges or Fixed Partial Dentures)</b>	
D6210	Pontic - cast high noble metal*	220.00
D6211	Pontic - cast predominantly base metal*	220.00
D6212	Pontic - cast noble metal*	220.00
D6240	Pontic - porcelain fused to high noble metal*	220.00
D6241	Pontic - porcelain fused to predominantly base metal*	220.00
D6242	Pontic - porcelain fused to noble metal*	220.00
D6250	Pontic - resin with high noble metal*	220.00
D6251	Pontic - resin with predominantly base metal*	220.00
D6252	Pontic - resin with noble metal*	220.00
D6253	Provisional pontic*	220.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis*	140.00
D6600	Inlay - porcelain-ceramic, two surfaces*	165.00
D6601	Inlay - porcelain-ceramic, three or more surfaces*	175.00
D6602	Inlay - cast high noble metal, two surfaces*	165.00
D6603	Inlay - cast high noble metal, three or more surfaces*	175.00
D6604	Inlay - cast predominantly base metal, two surfaces*	165.00
D6605	Inlay - cast predominantly base metal, three or more surfaces*	175.00
D6606	Inlay - cast noble metal, two surfaces*	165.00
D6607	Inlay - cast noble metal, three or more surfaces*	175.00
D6608	Onlay - porcelain-ceramic, two surfaces*	165.00
D6609	Onlay - porcelain-ceramic, three or more surfaces*	175.00
D6610	Onlay - cast high noble metal, two surfaces*	165.00
D6611	Onlay - cast high noble metal, three or more surfaces*	175.00
D6612	Onlay - cast predominantly base metal, two surfaces*	165.00
D6613	Onlay - cast predominantly base metal, three or more surfaces*	175.00
D6614	Onlay - cast noble metal, two surfaces*	165.00
D6615	Onlay - cast noble metal, three or more surfaces*	175.00
D6710	Crown - indirect resin based composite*	100.00
D6720	Crown - resin with high noble metal*	220.00
D6721	Crown - resin with predominantly base metal*	220.00
D6722	Crown - resin with noble metal*	220.00
D6740	Crown - porcelain/ceramic*	220.00
D6750	Crown - porcelain fused to high noble metal*	220.00
D6751	Crown - porcelain fused to predominantly base metal*	220.00
D6752	Crown - porcelain fused to noble metal*	220.00
D6780	Crown - 3/4 cast high noble metal*	189.00
D6781	Crown - 3/4 cast predominantly base metal*	170.00
D6782	Crown - 3/4 cast noble metal*	170.00
D6783	Crown - 3/4 porcelain/ceramic*	170.00
D6790	Crown - full cast high noble metal*	220.00
D6791	Crown - full cast predominantly base metal*	220.00
D6792	Crown - full cast noble metal*	220.00
D6794	Crown - titanium*	225.00
D6930	Recement fixed partial denture	15.00

ADA Code**	Service Description**	Member Copayment
D6940	Stress breaker	150.00
D6950	Precision attachment	195.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated*	150.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	150.00
D6973	Core build up for retainer, including any pins	100.00
D6976	Each additional indirectly fabricated post - same tooth*	75.00
D6977	Each additional prefabricated post - same tooth	60.00
D6980	Fixed partial denture repair, by report*	45.00
D9120	Fixed partial denture sectioning	65.00
None	Resin bonded bridge pontic, per unit***)	235.00
<b>Oral Surgery</b>		
D7111	Extraction, coronal remnants - deciduous tooth	22.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	30.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth(S)	60.00
D7220	Removal of impacted tooth - soft tissue(S)	70.00
D7230	Removal of impacted tooth - partially bony(S)	85.00
D7240	Removal of impacted tooth - completely bony(S)	125.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications(S)	150.00
D7250	Surgical removal of residual tooth roots (cutting procedure)(S)	40.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	100.00
D7280	Surgical access of an unerupted tooth	165.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	90.00
D7283	Placement of device to facilitate eruption of impacted tooth*	70.00
D7285	Biopsy of oral tissue - hard (bone, tooth)	70.00
D7286	Biopsy of oral tissue - soft	20.00
D7287	Exfoliative cytological sample collection	45.00
D7288	Brush biopsy - transepithelial sample collection	45.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant(S)	70.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	80.00
D7320	Alveoloplasty not in conjunction with extractions -four or more teeth or tooth spaces, per quadrant(S)	90.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	20.00
D7410	Excision of benign lesion up to 1.25 cm	70.00
D7471	Removal of lateral exostosis (maxilla or mandible)	75.00
D7472	Removal of torus palatinus	55.00
D7473	Removal of torus mandibularis	55.00
D7485	Surgical reduction of osseous tuberosity	55.00
D7510	Incision and drainage of abscess - intraoral soft tissue(S)	35.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	40.00
D7520	Incision and drainage of abscess - extraoral soft tissue	40.00
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	40.00
D7910	Suture of recent small wounds up to 5 cm	35.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure(S)	40.00

<b>ADA Code**</b>	<b>Service Description**</b>	<b>Member Copayment</b>
D7963	Frenuloplasty	50.00
D7970	Excision of hyperplastic tissue - per arch	60.00
D7971	Excision of pericoronal gingiva	60.00
	<b>Emergency Treatment of Pain</b>	
None	Palliative (emergency) service - treatment to evaluate, stabilize, and control pain including local anesthesia when necessary	45.00
	<b>Anesthesia, Analgesia, and Sedation</b>	
D9212	Trigeminal division block anesthesia	No Charge
D9220	Deep sedation/general anesthesia - first 30 minutes	130.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes	45.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	20.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes(S)	100.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes(S)	30.00
D9248	Non-intravenous conscious sedation	15.00
D9610	Therapeutic parenteral drug, single administration*	20.00
D9612	Therapeutic parenteral drugs, two or more administrations, different medications*	35.00
D9630	Other drugs and/or medicaments, by report*	20.00
D9910	Application of desensitizing medicament	15.00

‡More often if medically necessary as determined by attending Plan Dentist.

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

\*\*Current and prior versions of the current dental terminology (CDT) codes (in the **ADA Code** column) and descriptors (in the **Service Description** column) are copyrighted by the American Dental Association (ADA) and are used by permission.  
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\*\*\*Service does not have an American Dental Association current dental terminology code or descriptor.

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

The following Copayment Schedule applies to covered services when they are provided by a Plan Specialty Dentist. Member is responsible for paying the amount in the Member Copayment column either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures.

<b>ADA Code**</b>	<b>Service Description**</b>	<b>Member Copayment</b>
	<b>Orthodontics</b>	
None	Bracketing (for D8070, D8080 or D8090)***	300.00
D8070	Comprehensive orthodontic treatment of the transitional dentition	2000.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition (under 19 years)	2000.00
D8090	Comprehensive orthodontic treatment of the adult dentition (19 years or older)	2200.00
D8660	Pre-orthodontic treatment visit (consult/records/exam)	100.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	250.00

The Orthodontic Copayments listed above only apply during the first 24 months of active treatment and are only available once per lifetime. After 24 months of active treatment, the above Orthodontic Copayments are no longer applicable, and the listed services will be provided to Member at a 25% reduction from the Plan Specialty Dentist's normal retail charge. Member is responsible for paying the entire reduced charge either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures.

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

**SECTION III: NON-PLAN SPECIALTY DENTIST SERVICES**  
**(Subject to Limitations and Exclusions Listed in the Evidence of Coverage)**

The following schedule in this Section III applies to covered services when they are provided by a Non-Plan Specialty Dentist. Except for benefits for Emergency Services as specifically stated in the **EMERGENCY SERVICES** Article of the Evidence of Coverage, Member is responsible for paying the Non-Plan Specialty Dentist's entire normal retail charge for the service at the time the service is received or in accordance with the Non-Plan Specialty Dentist's billing procedures. Member may then submit a completed claim form, with the itemized bill attached, to Company. (Member may obtain claim forms by contacting Company.) Company will pay Member the lesser of the amount shown in the **Maximum Company Reimbursement** column or the amount charged by the Non-Plan Specialty Dentist for the service. Plan Benefit payments for services by Non-Plan Specialty Dentists are limited to a total of \$2,000.00 per calendar year.

<b>ADA Code**</b>	<b>Service Description**</b>	<b>Maximum Company Reimbursement</b>
	<b>Endodontics</b>	
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	415.00
D3330	Endodontic therapy, molar (excluding final restoration)	630.00
D3346	Retreatment of previous root canal therapy - anterior	280.00
D3347	Retreatment of previous root canal therapy - bicuspid	390.00

ADA Code**	Service Description**	Maximum Company Reimbursement
D3348	Retreatment of previous root canal therapy - molar	445.00
D3410	Apicoectomy/periradicular surgery - anterior	475.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	530.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	495.00
D3430	Retrograde filling - per root	135.00
<b>Periodontics</b>		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	400.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	110.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	550.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	180.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	135.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	100.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	85.00
<b>Oral Surgery</b>		
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	155.00
D7220	Removal of impacted tooth - soft tissue	175.00
D7230	Removal of impacted tooth - partially bony	220.00
D7240	Removal of impacted tooth - completely bony	240.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	280.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	160.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	195.00
D7320	Alveoloplasty not in conjunction with extractions -four or more teeth or tooth spaces, per quadrant	195.00
D7510	Incision and drainage of abscess - intraoral soft tissue	130.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	205.00
<b>Anesthesia, Analgesia, and Sedation</b>		
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	175.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	30.00

Plan Benefits are not available for any service that is both (a) received from a Non-Plan Specialty Dentist and (b) not listed on the Plan Benefit Schedule above. **Note: Plan Benefits are not available for Orthodontic services provided by a Non-Plan Specialty Dentist.**

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**Section IV: DENTAL IMPLANT SERVICES**  
**(Subject to Limitations and Exclusions Listed in the Evidence of Coverage)**

A \$300 reduction in the charges to the Member applies for the placement of an endosteal implant (ADA Code D6010) in conjunction with one of the following crowns ADA Code D6065, D6066, or D6067. This reduction in charges applies only when the implant is used instead of replacing a single missing tooth meeting the criteria of being replaced with traditional three (3) unit, cast bridge with single pontic. The space that was occupied by the single missing tooth must currently have a tooth mesial and distal to it. The tooth loss must have occurred within the twenty four (24) month period prior to the initiation of treatment. This reduction in charges is limited to the replacement of one tooth per each arch during the lifetime of the Member. Member is responsible for paying the entire charge less the \$300 reduction either at the time the service is received or in accordance with the Plan Dentist's or Plan Specialist's billing procedures. The treatment must be provided by a Plan Dentist or a Plan Specialty Dentist.

## HIPAA Notice of Privacy Practices

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

This Notice applies to our HIPAA covered dental and vision plans.

### Our Commitment

Union Security Insurance Company, Union Security Life Insurance Company of New York, and the prepaid dental companies\* are committed to protecting the personal information entrusted to us by our customers. The trust you place in us when you share your personal information is a responsibility we take very seriously and is the cornerstone of how we conduct our business.

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

### Our Use and Disclosure of Your PHI

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

Other examples of possible disclosures for purposes of healthcare operations include:

- Underwriting our risk and determining rates and premiums for your healthcare plan;
- Determining your eligibility for benefits;
- Reviewing the competence and qualifications of healthcare providers;
- Conducting or arranging for review, legal services, and auditing functions, including fraud and abuse detection and compliance;
- Business planning and development;

- Business management and general administrative duties such as cost-management, customer service, and resolution of internal grievances;
- Other administrative purposes.
- We can also make disclosures under the following circumstances without your permission:
- As required by law, including response to court and administrative orders, or to report information about suspected criminal activity;
- To report abuse, neglect, or domestic violence;
- To authorities that monitor our compliance with these privacy requirements;
- To coroners, medical examiners, and funeral directors;
- For research and public health activities, such as disease and vital statistic reporting;
- To avert a serious threat to health or safety;
- To the military, certain federal officials for national security activities, and to correctional institutions;
- To the entity sponsoring your group healthcare plan but only for purposes of enrollment, disenrollment, eligibility or for the purpose of giving the plan sponsor summary information when necessary to help make decisions regarding changes to the plan. If the plan sponsor has certified that its plan documents have been amended to include certain privacy provisions, we may also disclose protected health information to the plan sponsor to carry out plan administration functions that the plan sponsor performs on behalf of the plan;
- To a spouse, family member, or other personal representative if they can show they are assisting in your care or payment of your care and then, without an authorization, only basic information about the status or payment of a claim.

**Unless you give us written authorization, we cannot use or disclose your PHI for any reason except as otherwise described in this notice, including uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute the sale of protected health information. We are prohibited from using or disclosing your protected health**

Insurance products are underwritten by Union Security Insurance Company (USIC) (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (SLOC) (Wellesley Hills, MA) in all states except New York. Prepaid dental products are provided by USIC and are administered by SLOC, and are provided by prepaid dental companies affiliated with SLOC in certain states except New York. Prepaid dental companies are Denticare of Alabama, Inc., United Dental Care of Arizona, Inc., UDC Dental California, Inc., United Dental Care of Colorado, Inc., Union Security DentalCare of Georgia, Inc., United Dental Care of Michigan, Inc., United Dental Care of Missouri, Inc., Union Security DentalCare of New Jersey, Inc., United Dental Care of New Mexico, Inc., UDC Ohio, Inc., United Dental Care of Texas, Inc., and United Dental Care of Utah, Inc. In New York, insurance products and prepaid dental products are underwritten or provided by Union Security Life Insurance Company of New York (Fayetteville, NY) and administered by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).

information that is genetic information for underwriting purposes. You may revoke your written authorization at any time by writing us at the address indicated at the end of this notice.

### **Your Individual Rights**

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

- **To Restrict our Use or Disclosure.** You have the right to ask us to limit our use or disclosure of your PHI. While we will consider your request, we are not legally required to agree to the additional restrictions. If we do agree to all or part of your request, we will inform you in writing. We cannot agree to limit any use and disclosure of your PHI if the use or disclosure is required by law.
- **To Access your PHI.** You have the right to view and/or copy your PHI at any time by contacting us. If you want copies of your PHI, or want your PHI in a special format, we may charge you a fee. You have a right to choose what portions of your PHI you want copied and to have prior notice of copying costs. If for some reason we deny your request for access to your PHI, we will provide a written explanation of why your request was denied and explain how you can appeal the denial.
- **To Amend your PHI.** You have the right to amend your PHI, if you believe it is incomplete or inaccurate. Your request must be in writing, with an explanation of why you feel the information should be amended. If we approve your request to amend your PHI, we will make reasonable efforts to inform others, including people you name, about the amendment to your PHI. We may deny your request for various reasons, for example, if we determine that the information is correct and complete, or if we did not create the information. If we deny your request, we will provide you a written explanation of our decision. We also will explain your rights regarding having your request and our response included with all future disclosures of your PHI.
- **To Obtain an Accounting of our Disclosures.** You have the right to receive a listing from us of all instances in the past six years in which we or our business associates have disclosed your PHI for purposes other than treatment, payment, health care operations, or as authorized by you. The accounting will tell you the date we made the disclosure, the name of the person or entity to whom the disclosure was made, a description of the PHI that was disclosed, and the reason for the disclosure. There may be a charge for accounting disclosures if requested more than once a year.
- **To Request Alternative Communications.** You have the right to ask us to communicate with you about your confidential information by a different method or at another location. We will accommodate all reasonable requests.
- **To Be Notified of a Breach:** You will be notified in the event that unsecured protected health information is compromised.
- **To Receive Notice.** You are entitled to receive a copy of this notice that outlines our HIPAA privacy practices. We reserve the right to change these

practices and the terms of this notice at any time. We will not make any material changes to our privacy practices without first sending you a revised notice. If you receive this notice on our web site or by electronic mail, you may request a paper copy.

### **Who to Contact for Questions and Complaints**

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

**Mailing Address:** Sun Life Financial  
Privacy Officer  
P.O. Box 419052  
Kansas City, MO 64141-6052

**Telephone:** 800.733.7879

**Email:** SLF\_US\_Privacy@sunlife.com

**Web Site:** [www.sunlife.com/us](http://www.sunlife.com/us)

### **For New York business:**

**Mailing Address:** Union Security Life Insurance  
Company of New York  
Privacy Officer  
Administered by:  
Sun Life Financial  
P.O. Box 419052  
Kansas City, MO 64141-6052

**Telephone:** 888.901.6377

**Email:** SLF\_US\_Privacy@sunlife.com

### **Organizations Covered by This Notice**

This notice applies to the privacy practices of the organizations referenced below. These organizations may share your PHI with each other as needed for payment activities or health care operations relating to the healthcare plans that we provide.

**Effective Date of This Notice:** April 14, 2003.

**Revised:** October 21, 2016

\* In this notice, "we," "us," and "our" refer to Union Security Insurance Company, Union Security Life Insurance Company of New York and the following prepaid dental companies: DentiCare of Alabama, Inc., Union Security DentalCare of Georgia, 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., Union Security DentalCare of New Jersey, 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 Department of Insurance and Financial Institutions ("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 and Financial Institutions, Consumer Affairs Division, 100 N. 15th Avenue, Suite 102, Phoenix, AZ 85007-2624.

### **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)

Level 1 Expedited Dental Review

Level 2 Expedited Appeal

Level 3 Expedited External Independent  
Dental Review

#### **Standard Appeals**

(for non- urgent services or denied  
claims)

Informal Reconsideration<sup>1</sup>

Formal Appeal

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.

<sup>1</sup> An informal reconsideration is not available for a denied claim.

<p><b>EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED</b></p>
--

#### **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 of Insurance and Financial Institutions, 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 Department of Insurance and Financial Institutions 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 72 hours 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 4 months 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 4 months 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 4 months 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 Department and Financial Institutions, 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 Department of Insurance and Financial Institutions 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 Arizona Department of Insurance and Financial Institutions 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 Arizona Department of Insurance and Financial Institutions 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 \_\_\_\_\_

2323 Grand Boulevard  
Kansas City, MO 64108

## SAMPLE FULFILLMENT PACKET FOR FREEDOM BASIC

802 - G933  
ARIZONA RETIREE  
123 CHERRY ST  
PHOENIX, AZ 85005

G933 0020 E6 FNAE7B FREEDOM BASIC DHP AZ 20200101 12/13/2019



Thank you for selecting Sun Life\* for your dental product. We are pleased to provide you with the attached dental identification cards. If you have previously received cards, please replace your current ID cards with the attached cards.

Register today for a Sun Life account at [www.sunlife.com/account](http://www.sunlife.com/account). A Sun Life account provides you with the ability to:

- Download your ID card
- View benefit and claims information
- Find a dentist

### Go Mobile!

Scan the code on the right (or go to [www.sunlife.com/mobileapps](http://www.sunlife.com/mobileapps)) to download our mobile app, **Benefit Tools**, to access many of the same resources as your Sun Life account.



If you have any questions, please call the toll- free number listed on your ID card.

You always have the freedom to choose any dentists with your dental plan. When using an in- network dentist, you may save on out- of- pocket costs.

\*Insurance products are underwritten by Union Security Insurance Company (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (Wellesley Hills, MA).

© 2019 Sun Life Assurance Company of Canada, Wellesley Hills, MA 02481. All rights reserved. Sun Life and the globe symbol are registered trademarks of Sun Life Assurance Company of Canada. Visit us at [www.sunlife.com/us](http://www.sunlife.com/us).

Sun Life's dental networks include dentists contracted with Dental Health Alliance, L.L.C.® (D.H.A.®) and dentists under access arrangements with other dental networks.

BATCH  
GF

## Membership Cards



GROUP ID NUMBER  
G933

ISSUED TO  
ARIZONA STATE RETIREMENT  
SYSTEM

MEMBER SIGNATURE

Insurance products are underwritten by Union Security Insurance Company (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (Wellesley Hills, MA).



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**Assurant Dental Network®**  
(Includes Aetna Dental® Administrators)

To locate a dentist in your area – visit [www.sunlife.com/findadentist](http://www.sunlife.com/findadentist). Input your Group ID and hit search.

**Dental Coverage:** Benefits are subject to group provisions including deductibles, coinsurance and coordination of benefits. This card is NOT a guarantee of payment. Please call to verify benefits. If services are to exceed \$300, please submit a pre- determination.

**Vision Service Plan (VSP):** Present this card to obtain discounts from VSP providers. To locate a provider, call 800- 877- 7195 or visit [www.vsp.com](http://www.vsp.com). This is not insurance.

**For Benefit and Claim Information:**

Sun Life  
P.O. Box 2940, Clinton, IA 52733

**Electronic Claims:** Payor 70408  
800- 442- 7742

**Assurant Dental Network®**  
(Includes Aetna Dental® Administrators)

To locate a dentist in your area – visit [www.sunlife.com/findadentist](http://www.sunlife.com/findadentist). Input your Group ID and hit search.

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P.O. Box 2940, Clinton, IA 52733

**Electronic Claims:** Payor 70408  
800- 442- 7742

## HIPAA Notice of Privacy Practices

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

This Notice applies to our HIPAA covered dental and vision plans.

### Our Commitment

Union Security Insurance Company, Union Security Life Insurance Company of New York, and the prepaid dental companies\* are committed to protecting the personal information entrusted to us by our customers. The trust you place in us when you share your personal information is a responsibility we take very seriously and is the cornerstone of how we conduct our business.

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

### Our Use and Disclosure of Your PHI

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

Other examples of possible disclosures for purposes of healthcare operations include:

- Underwriting our risk and determining rates and premiums for your healthcare plan;
- Determining your eligibility for benefits;
- Reviewing the competence and qualifications of healthcare providers;
- Conducting or arranging for review, legal services, and auditing functions, including fraud and abuse detection and compliance;
- Business planning and development;

- Business management and general administrative duties such as cost-management, customer service, and resolution of internal grievances;
- Other administrative purposes.
- We can also make disclosures under the following circumstances without your permission:
- As required by law, including response to court and administrative orders, or to report information about suspected criminal activity;
- To report abuse, neglect, or domestic violence;
- To authorities that monitor our compliance with these privacy requirements;
- To coroners, medical examiners, and funeral directors;
- For research and public health activities, such as disease and vital statistic reporting;
- To avert a serious threat to health or safety;
- To the military, certain federal officials for national security activities, and to correctional institutions;
- To the entity sponsoring your group healthcare plan but only for purposes of enrollment, disenrollment, eligibility or for the purpose of giving the plan sponsor summary information when necessary to help make decisions regarding changes to the plan. If the plan sponsor has certified that its plan documents have been amended to include certain privacy provisions, we may also disclose protected health information to the plan sponsor to carry out plan administration functions that the plan sponsor performs on behalf of the plan;
- To a spouse, family member, or other personal representative if they can show they are assisting in your care or payment of your care and then, without an authorization, only basic information about the status or payment of a claim.

**Unless you give us written authorization, we cannot use or disclose your PHI for any reason except as otherwise described in this notice, including uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute the sale of protected health information. We are prohibited from using or disclosing your protected health**

Insurance products are underwritten by Union Security Insurance Company (USIC) (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (SLOC) (Wellesley Hills, MA) in all states except New York. Prepaid dental products are provided by USIC and are administered by SLOC, and are provided by prepaid dental companies affiliated with SLOC in certain states except New York. Prepaid dental companies are Denticare of Alabama, Inc., United Dental Care of Arizona, Inc., UDC Dental California, Inc., United Dental Care of Colorado, Inc., Union Security DentalCare of Georgia, Inc., United Dental Care of Michigan, Inc., United Dental Care of Missouri, Inc., Union Security DentalCare of New Jersey, Inc., United Dental Care of New Mexico, Inc., UDC Ohio, Inc., United Dental Care of Texas, Inc., and United Dental Care of Utah, Inc. In New York, insurance products and prepaid dental products are underwritten or provided by Union Security Life Insurance Company of New York (Fayetteville, NY) and administered by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).

information that is genetic information for underwriting purposes. You may revoke your written authorization at any time by writing us at the address indicated at the end of this notice.

### **Your Individual Rights**

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

- **To Restrict our Use or Disclosure.** You have the right to ask us to limit our use or disclosure of your PHI. While we will consider your request, we are not legally required to agree to the additional restrictions. If we do agree to all or part of your request, we will inform you in writing. We cannot agree to limit any use and disclosure of your PHI if the use or disclosure is required by law.
- **To Access your PHI.** You have the right to view and/or copy your PHI at any time by contacting us. If you want copies of your PHI, or want your PHI in a special format, we may charge you a fee. You have a right to choose what portions of your PHI you want copied and to have prior notice of copying costs. If for some reason we deny your request for access to your PHI, we will provide a written explanation of why your request was denied and explain how you can appeal the denial.
- **To Amend your PHI.** You have the right to amend your PHI, if you believe it is incomplete or inaccurate. Your request must be in writing, with an explanation of why you feel the information should be amended. If we approve your request to amend your PHI, we will make reasonable efforts to inform others, including people you name, about the amendment to your PHI. We may deny your request for various reasons, for example, if we determine that the information is correct and complete, or if we did not create the information. If we deny your request, we will provide you a written explanation of our decision. We also will explain your rights regarding having your request and our response included with all future disclosures of your PHI.
- **To Obtain an Accounting of our Disclosures.** You have the right to receive a listing from us of all instances in the past six years in which we or our business associates have disclosed your PHI for purposes other than treatment, payment, health care operations, or as authorized by you. The accounting will tell you the date we made the disclosure, the name of the person or entity to whom the disclosure was made, a description of the PHI that was disclosed, and the reason for the disclosure. There may be a charge for accounting disclosures if requested more than once a year.
- **To Request Alternative Communications.** You have the right to ask us to communicate with you about your confidential information by a different method or at another location. We will accommodate all reasonable requests.
- **To Be Notified of a Breach:** You will be notified in the event that unsecured protected health information is compromised.
- **To Receive Notice.** You are entitled to receive a copy of this notice that outlines our HIPAA privacy practices. We reserve the right to change these

practices and the terms of this notice at any time. We will not make any material changes to our privacy practices without first sending you a revised notice. If you receive this notice on our web site or by electronic mail, you may request a paper copy.

### **Who to Contact for Questions and Complaints**

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

**Mailing Address:** Sun Life Financial  
Privacy Officer  
P.O. Box 419052  
Kansas City, MO 64141-6052

**Telephone:** 800.733.7879

**Email:** SLF\_US\_Privacy@sunlife.com

**Web Site:** [www.sunlife.com/us](http://www.sunlife.com/us)

### **For New York business:**

**Mailing Address:** Union Security Life Insurance  
Company of New York  
Privacy Officer  
Administered by:  
Sun Life Financial  
P.O. Box 419052  
Kansas City, MO 64141-6052

**Telephone:** 888.901.6377

**Email:** SLF\_US\_Privacy@sunlife.com

### **Organizations Covered by This Notice**

This notice applies to the privacy practices of the organizations referenced below. These organizations may share your PHI with each other as needed for payment activities or health care operations relating to the healthcare plans that we provide.

**Effective Date of This Notice:** April 14, 2003.

**Revised:** October 21, 2016

\* In this notice, "we," "us," and "our" refer to Union Security Insurance Company, Union Security Life Insurance Company of New York and the following prepaid dental companies: DentiCare of Alabama, Inc., Union Security DentalCare of Georgia, 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., Union Security DentalCare of New Jersey, Inc.

# **Group Dental Benefits**

**Arizona State Retirement  
System**

**Basic Plan-Amended  
01/01/2020**

**G933**

**CERTIFICATE OF  
GROUP INSURANCE**

---

**Union Security Insurance Company** certifies that the insurance stated in this Certificate became effective on the Effective Date shown in your Schedule. This Certificate is subject to the provisions of the below numbered *policy* issued by Union Security Insurance Company to the *policyholder*.

Policyholder: Arizona State Retirement System

Policy Number: G933

This Certificate replaces any and all Certificates and Certificate Endorsements, if any, issued to you under the *policy*.

A handwritten signature in black ink, reading "Joe Roberts". The signature is written in a cursive style with a large, looping initial "J" and a horizontal line extending from the end of the name.

President and Chief Executive Officer



## SCHEDULE

### Eligible Persons

To be eligible for insurance, a person must be a member of an Eligible Class. The person must also complete a period of continuous service (Service Requirement) with the *policyholder* (or any *associated company*).

### Eligible Class:

For employee insurance - Each retired employee of the policyholder or an associated company.

For dependent insurance - Each person eligible for employee insurance.

**Associated Companies:** None

**Present Service Requirement:** None

**Future Service Requirement:** None

### Entry Date

Insurance will take effect on the later of (i) the date shown below, or (ii) the first of the month occurring on or after the day all eligibility requirements are met.

### Effective Date of Insurance

January 1, 2003 (Subject to Entry Date)

## SCHEDULE

### Dental Insurance

#### Deductible Amount

Individual Deductible Amount Per <i>Policy Year</i>	\$ 50
Maximum Family Deductible per <i>policy year</i>	3 persons
The Individual Deductible does not apply to Type I Dental Services	

#### Coinsurance Percentages

Type I Services	100 %
Type II Services	80 %

#### Benefit Maximums:

<i>Policy Year</i> Maximum	\$ 1000
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Covered dental expenses incurred for Type I Dental Services will not be applied to the Policy Year Maximum.

Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the Listing of Covered Dental Services. However, benefits will be payable based on the most current dental terminology.

#### Vision Plan

You and your *covered dependents* are eligible for discounted vision services. The discounted vision services are provided through a third party vendor and are not covered under an insured plan. The discounted vision services offered include discounts on eye exams, prescription glasses, and services related to prescription contact lenses.

#### Plan Changes

You may change your plan of insurance only during the annual enrollment period agreed upon by the *policyholder* and us, unless you undergo a change in family status. A plan change made during the annual enrollment period will take effect on the next following *policy* anniversary.

You may change your plan within 31 days of a change in family status. The effective date of the change will be the Entry Date occurring on or after the date of the request.

A "change in family status" means your marriage or divorce, the birth or adoption of your child, the death of your spouse or child, the termination of employment of your spouse.

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## GENERAL DEFINITIONS

These terms have the meanings shown here when *italicized*. The pronouns we, us, our, you, and your are not *italicized*.

*Associated company* means any company shown in the *policy* which is owned by or affiliated with the *policyholder*.

*Contributory* means you pay part or all of the premium.

*Covered dependent* means an *eligible dependent* who is insured under the *policy*.

*Covered person* means an eligible employee or member of the *policyholder*, or an *associated company* who has become insured for a coverage.

*Doctor* means a person, other than you, acting within the scope of his or her license to practice medicine and perform surgery.

*Eligible class* means a class of persons eligible for insurance under the *policy*. This class is based on employment or membership in a group.

*Home office* means our office in Kansas City, Missouri.

*Injury* means accidental bodily *injury*. It does not mean intentionally self-inflicted *injury* while sane or insane.

*No-fault motor vehicle coverage* means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident that occurs.

*Policy* means the group *policy* issued by us to the *policyholder* that describes the benefits for which you may be eligible.

*Policyholder* means the entity to whom the *policy* is issued.

*Proof of good health* means evidence acceptable to us of the good health of a person.

We, us and our mean Union Security Insurance Company.

You and your mean an employee or member of the *policyholder* or an *associated company* who has met all the eligibility requirements for a coverage.

## DEFINITIONS FOR DENTAL INSURANCE

*Accidental non-chewing injury* means an *injury* (other than a chewing injury) sustained while insured under the *policy*, which is caused solely and exclusively by an accident which could not be predicted in advance, and which could not be avoided. A chewing injury is any *injury* which occurs during the act of biting or chewing, regardless of whether the *injury* is caused by biting or chewing food, biting on a foreign object not expected to be a normal constituent of food, parafunctional or abnormal habits such as (but not limited to) chewing on eyeglass frames or pencils, biting down on a suddenly dislodged or loose dental appliance, or biting or chewing on any other object for any other reason.

*Allowable charge* means a charge that is based on the general level of charges made by other providers in the area for like *treatment*. Our determination of what is an *allowable charge* is final for the purpose of determining benefits payable under the *policy*.

*Benefit year* means a period of 12 consecutive months, which begins on the date you become insured under the *policy*. Subsequent *benefit years* begin on each succeeding anniversary of the date you became insured under the *policy*.

*Dental hygienist* means an individual who is licensed to practice dental hygiene and acting under the supervision of a *dentist* within the scope of that license in treating the dental condition.

*Dental insurance* means the group dental insurance under the *policy* issued by us to the *policyholder*.

*Dentally necessary and dental necessity* mean a service or *treatment* which is appropriate with the diagnosis and which is in accordance with accepted dental standards. The service or *treatment* must be essential for the care of the teeth and supporting tissues.

*Dental treatment plan* means the *dentist's* report of recommended *treatment* which contains:

- a list of the charges and dental procedures required for the *dentally necessary* care;
- any supporting pre-operative x-rays; and
- any other appropriate diagnostic materials required by us.

*Dentist* means an individual who is licensed to practice dentistry and acting within the scope of that license in treating the dental condition.

*Denturist* means an individual who is licensed to make dentures and acting within the scope of that license in treating the dental condition.

*Emergency dental treatment* means any *dentally necessary treatment* that is rendered as the direct result of unforeseen events or circumstances, which require prompt attention.

*Functioning natural tooth* means a *natural tooth* which is performing its normal role in the chewing process in the person's upper or lower arch and which is opposed in the person's other arch by another *natural tooth* or prosthetic replacement.

*Immediate family* means a person who is related to you or your spouse in any of the following ways: parent, spouse, child, brother, sister, or grandparent.

*Medicare* means a portion of Title XVIII of the United States Social Security Act of 1965, as amended.

*Natural tooth* means any tooth or part of a tooth that is organic and formed by the natural development of the body. Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

*Orthodontic treatment* means the corrective movement of teeth through the bone by means of an active appliance to correct a handicapping malocclusion (a malocclusion severely interfering with a persons ability to

## DEFINITIONS FOR DENTAL INSURANCE (continued)

chew food) of the mouth. We will make the determination of the severity of the malocclusion.

*Other group dental expense coverage* means:

- Any other group *policy* providing benefits for dental expenses; or
- Any plan providing dental expense benefits (whether through a dental services organization or other party providing prepaid health or related services) which is arranged through any employer or through direct contact with persons eligible for that plan.

*Policy year* means the period of time which begins on the *policy* anniversary date of each calendar year and ends on the day before the next following yearly *policy* anniversary date. The first *policy year* begins on the *policy* effective date. The last *policy year* ends on the day *dental insurance* under the *policy* ends.

*Sound tooth* means a *natural tooth* that is fully restored to function, does not have any decay, is not more susceptible to injury than a virgin tooth, and is without periodontal disease.

*Treatment* means any dental consultation, service, supply, or procedure that is needed for the care of the teeth and supporting tissues.



## ELIGIBILITY AND TERMINATION PROVISIONS FOR YOU

### When Your Insurance Ends

Your insurance will end on the date:

- the *policy* ends;
- the *policy* is changed to end the insurance for your *eligible class*;
- you are no longer in an *eligible class*;
- a required contribution was not paid; or
- you become covered under an optional dental plan, which is sponsored by your employer, or the policyholder, or an associated company and provided through a Dental Maintenance Organization.

## ELIGIBILITY AND TERMINATION PROVISIONS FOR DEPENDENTS

### Eligible Dependents

Your *eligible dependents* are:

- your lawful spouse, and
- your children who are less than age 26.

Children" include any adopted children. A child will be considered adopted on the date of placement in your home. Stepchildren and foster children are also included if they depend on you for support and maintenance. "Children" also include any children for whom you are the legal guardian, who reside with you on a permanent basis and depend on you for support and maintenance.

An *eligible dependent* will not include any person who is a member of an *eligible class*. An *eligible dependent* may not be covered by more than 1 *covered person*.

### Dependent Effective Date

You must apply for dependent insurance on a form acceptable to us. You must also agree to pay your share of the premium.

- If you apply before the dependent becomes eligible, dependent insurance will take effect on the Entry Date shown in the Schedule in the *policy*.
- If you apply on the date the dependent becomes eligible, or within 31 days after that, dependent insurance will take effect on the Entry Date occurring on or after the date of your application.
- If you apply more than 31 days after the date the dependent becomes eligible or after dependent insurance ended because the premium was not paid, then application must be made during an annual enrollment period. Dependent insurance will take effect on the *policy* anniversary occurring on or after the date of application.

### Exception to Dependent Effective Date

Dependent insurance will not take effect until your insurance for the same coverage under the policy takes effect.

If an *eligible dependent* is in a hospital or similar facility on the day insurance would otherwise take effect, it will not take effect until the day after the *eligible dependent* leaves the hospital or similar facility. This exception does not apply to a child born while dependent insurance is in effect.

### When Dependent Insurance Ends

A dependent's insurance will end on the earliest of:

- the day the *policy* ends;
- the day the *policy* is changed to end dependent insurance;
- the last day of the month in which that dependent is no longer eligible;
- the day your insurance for the same coverage under the *policy* ends;
- the day a required contribution for dependent insurance was not paid; or

## ELIGIBILITY AND TERMINATION PROVISIONS FOR DEPENDENTS (continued)

- the day the dependent becomes covered under an optional dental plan which is sponsored by your employer, or the *policyholder*, or an *associated company* and provided through a Dental Maintenance Organization.

### SPECIAL DEPENDENT INSURANCE CONTINUANCE PROVISIONS

As specified below, dependent *dental insurance* may continue, subject to the provisions that describe when insurance ends, and all other terms and conditions of the *policy*. Premiums are required for any coverage continued.

#### Physically Handicapped or Mentally Retarded Dependent Children

Dependent *dental insurance* for an *eligible dependent* child will continue beyond the date a child attains an age limit, if, on that date, he or she:

- is unable to earn a living because of physical handicap or mental retardation; and
- is chiefly dependent upon you for support and maintenance.

We must receive proof of the above within 120 days after the child attains the age limit and each year after that, beginning 2 years after the child attains the age limit. There will be no increase in premium for this continued coverage.

Dependent *dental insurance* will end when the child is able to earn a living or is no longer dependent on you for support and maintenance.

## **SPECIAL FEDERAL CONTINUANCE PROVISIONS**

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered dependents may have the right to continue dental insurance coverage beyond the date insurance would otherwise terminate. You should contact the policyholder concerning your right to continue coverage.

## DENTAL INSURANCE

### Insurance Provided

We will pay benefits for covered dental expenses identified in the *policy* when incurred by you or a *covered dependent*, while covered under the *policy*. We will pay the coinsurance percentage shown in the Schedule after you or a *covered dependent* have satisfied any deductible required for the *policy year*, subject to all the terms and conditions of the *policy*.

Covered dental expenses will only include *treatment* provided to you or a *covered dependent* for which, as outlined in the Listing of Covered Dental Services provision, the date started and the date completed occur while the person is insured under the *policy*. No payment will be made for a program of dental *treatment* already in progress on the effective date of a person's insurance. No payment will be made for dental *treatment* completed after your or a *covered dependent's* insurance under the *policy* ends, except as stated in the Limited Extension of Benefits After Insurance Ends provision.

### Deductible

The deductible is the amount shown in the Schedule and will be applied to each type of dental services as indicated in the Schedule. The deductible is the amount of covered dental expenses that you and each *covered dependent* must incur in a *policy year* before we will pay benefits. When covered dental expenses equal to the deductible amount have been incurred and submitted to us, the deductible will be satisfied. We will not pay benefits for covered dental expenses applied to the deductible.

If the deductible amount is increased during a *policy year*, further covered dental expenses must be incurred after the date of increase to satisfy the additional deductible for that *policy year*.

The deductible will apply to you and each *covered dependent* separately each *policy year*, . except as stated in the Maximum Family Deductible Section.

### Maximum Family Deductible

The family deductible is shown in the Schedule. It indicates the number of persons in your family unit who must each satisfy an individual deductible in order to satisfy the family deductible. Once that number of persons has satisfied a deductible for a *policy year*, we will consider the deductible to be satisfied for each person in your family unit for that *policy year*. We will pay benefits for covered dental expenses incurred on or after the date the required number of persons has satisfied the deductible amount.

### Policy Year Maximum

The maximum benefit payable to you and each *covered dependent* during a *policy year* is shown in the Schedule. This maximum will apply even if coverage for you or a *covered dependent* ends and starts again within the same *policy year* or if you or a *covered dependent* have been covered both as an employee and a dependent. Benefits paid for Type I Dental Services will not be applied to the Policy Year Maximum.

### Date Started and Completed

We consider a *dental treatment* to be started and completed the date *treatment* is rendered.

### Pre-estimate

Whenever the expected cost of a *treatment* exceeds \$300, we recommend that a *dental treatment plan* be submitted to us for review before *treatment* begins. The *dental treatment plan* should be accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials as requested by us. We will notify you and your *dentist* of the benefits payable based upon the *dental treatment plan*. In estimating the amount of benefits payable, consideration will be given to the least costly alternative procedures and materials that may accomplish a result that meets broadly accepted standards of professional dental care as determined by us.

If a *dental treatment plan* is not completed within six months of the pre-estimate, we may consider it invalid. We may request the submission of a new *dental treatment plan*.

If you and your *dentist* decide on a more costly method of *treatment* than that pre-estimated by us, benefits

## DENTAL INSURANCE (continued)

payable for covered dental services for the more costly *treatment* will be limited to the benefits that would have been payable for covered dental services for the least costly alternative *treatment*. We will not pay the excess amount. Since this may result in significant out-of-pocket expense, we strongly encourage you to receive a pre-estimate for any *dental treatment plan* that is expected to exceed \$300 in cost.

### Alternative Benefits

In determining the benefits payable on a claim, we will consider other alternative procedures and materials that can be used to treat a dental problem or disease. The covered dental expense for a covered dental service provided will be limited to the *allowable charge* for the least costly covered dental service that accomplishes a result which meets broadly accepted standards of professional dental care as determined by us. You and your *dentist* may decide on a more costly procedure or material than we have determined to be satisfactory for the *treatment* of the dental problem or disease. In this event, we will not pay the excess amount. The benefit payable will be limited to the benefit that would have been payable had the least costly covered dental service been provided instead.

### Covered Dental Expenses

Covered dental expenses include only the lesser of the *dentists* actual charge or the *allowable charge* for expenses incurred by you or a *covered dependent*. The *treatment* must be:

- performed by or under the direction of a *dentist*, or performed by a *dental hygienist* or denturist;
- *dentally necessary*; and
- started and completed while you or your *covered dependent* are insured, except as otherwise provided in the Limited Extension of Benefits After Insurance Ends provision.

Expenses submitted to us must identify the *treatment* performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request X-rays, narratives and other diagnostic information, as we see fit, to determine benefits.

We will only pay benefits for covered dental expenses incurred for *treatment* that, in our opinion, has a reasonably favorable prognosis for the patient.

We consider a temporary *treatment* to be an integral part of the final *treatment*. The sum of the fees for temporary and final *treatment* will be used to determine whether the charges are an *allowable charge*.

The Listing of Covered Dental Services is a complete list of covered dental services. We will not pay benefits for expenses incurred for any service not listed below, unless we agree to accept an unlisted service as a covered dental service. We will not accept any unlisted service which is not similar to, or which does not accomplish a result similar to, a listed service. In any event, the choice of whether or not to accept an unlisted service is solely ours. If we do accept an unlisted service as a covered dental service, benefits will be payable on a basis consistent with benefits for similar covered dental services which would provide the least costly adequate *treatment* of your or your *covered dependents* dental condition according to broadly accepted standards of professional dental care as determined by us.

### Listing of Covered Dental Services

Maximum frequencies, maximum dollar amounts and other limits are shown here and under Special Limitations and General Exclusions for certain services. Services performed outside these limits are not covered dental services. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the Listing of Covered Dental Services. However, benefits will be payable based on the most current dental terminology.

## DENTAL INSURANCE (continued)

### Type I Dental Services

- Clinical Oral Evaluations
  - No more than 2 times per Calendar Year. Benefits are based on the *allowable charge* for periodic oral evaluation.
- Dental Prophylaxis
  - No more than 2 times per Calendar year. (Frequencies combined with periodontal maintenance.)
- Topical Fluoride Treatment
  - No more than 1 time in any 12 months in a row. Only for children under age 14 years.
- Sealants
  - No more than 1 time per tooth per person. Only for children under age 16 years. Only for permanent molar teeth.
- Space Maintenance (Passive Appliances)
  - Only for children under age 16 years. Service is deemed to include all adjustments made, or recementing done, within 6 months of installation.
- Treatment To Control Harmful Habits
  - Not covered if orthodontic related. Once per person. Only for children under age 16 years.
- Radiographs-Diagnostic Imaging
  - Bitewings no more than 1 time in any 12 months in a row.

### Type II Dental Services

- Radiographs-Diagnostic Imaging
  - Complete Series (Including Bitewings) or Panoramic Film -- No more than 1 time in any 60 months in a row. A complete series is deemed to include bitewing x-rays and 10 or more periapical x-rays, or a panoramic film
    - One of either service no more than 1 time in any 60 months in a row. Benefits for a panoramic film may also be payable in connection with the removal of impacted teeth.
  - Periapical -- No more than 4 x-rays in any 12 months in a row.
  - Occlusal Film -- No more than 2 films in any 12 months in a row.
  - Extraoral -- No more than 2 films in any 12 months in a row.
  - Sialography
- Minor Restorations (Fillings)
  - Amalgam and Composite Restorations
    - Replacement of existing minor restoration (filling) is deemed to be a covered dental service only if at least 24 months have passed since existing minor restoration (filling) was placed, unless

## DENTAL INSURANCE (continued)

required by new decay in an additional tooth surface.

- The service is deemed to include local anesthesia.
- Multiple restorations on one surface are deemed to be a single restoration.
- Mesial-lingual, distal-lingual, mesial-facial, and distal-facial resin restorations on anterior teeth are deemed to be single surface restorations.

- Other Restorative Services

- Pin Retention -- No more than 1 time per restoration. Deemed to be a covered dental service only in conjunction with amalgam or resin restoration.

- Oral Surgery

- Minor Oral Surgery -- Each service is deemed to include local anesthesia and routine postoperative care.
  - Simple Extractions (Does not include Surgical Extractions)
  - Surgical Incision and Drainage of Abscess
  - Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

- Minor Periodontics

- Adjunctive Periodontal Service
  - Provisional Splinting -- covered dental services do not include inlays, onlays, crowns, or other cast or prepared restorations made for the purpose of splinting.
  - Scaling and Root Planing -- no more than 1 time per area of the mouth in any 24 months in a row. The benefit for three or more quadrants of scaling and root planing, performed during the same appointment, will be limited to benefits equivalent to one quadrant of scaling and root planing. Benefits for prophylaxis and scaling and root planing, performed during the same appointment, will be based on the allowable charge for a prophylaxis. Benefits for scaling and root planing and periodontal maintenance, performed during the same appointment, will be based on the *allowable charge* for periodontal maintenance.
  - Occlusal Adjustment -- no more than 1 full mouth treatment in any 12 months in a row. Only when performed with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service).

- Other Periodontal Services

- Periodontal Maintenance -- no more than 2 times per Calendar year. Service is deemed to include scaling and root planing, a recall evaluation, charting, polishing of teeth, and oral hygiene instruction. (Frequencies combined with prophylaxis.)

- Other Type II Services

- Bacteriologic Studies For Determination of Pathologic Agents
- Palliative (Emergency) Treatment of Dental Pain - Minor Procedure Deemed to be a separate



## DENTAL INSURANCE (continued)

covered dental service only if no other service is rendered during the visit, except x-rays.

- Therapeutic Drug Injection
- Accession and examination of tissue

### Special Limitations

#### Coverage Under the Group's Medical Plan

If benefits for any covered dental expenses are provided under your employer's medical plan (if any), benefits otherwise payable for those expenses under the policy will be reduced by the amount of benefits payable for those expenses under your employer's medical plan.

#### General Exclusions

Covered dental expenses and covered dental services do not include, and we will not pay benefits for, the following:

- *treatment* which:
  - is not included in the list of covered dental services; or
  - has a date started before your or a *covered dependent's* insurance begins; or
  - has a date started before any applicable waiting period has been served; or
  - has a date completed after your or a *covered dependents* insurance ends, except as may be specifically provided under Limited Extension of Benefits After Insurance Ends.
- any *treatment*, the sole or primary purpose of which relates to:
  - the change or maintenance of vertical dimension; or
  - the alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service); or
  - bite registration; or
  - bite analysis.
- any *treatment* required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint or its associated structures.
- athletic mouthguards; replacement of lost or stolen appliances; myofunctional therapy; infection control; oral hygiene instruction; separate charges for acid etch; *treatment* of jaw fractures; orthognathic surgery; personal supplies; broken appointments; completion of claim forms; exams required by a third party; travel time; transportation costs; professional advice given on the phone.
- *treatment* which:
  - is not *dentally necessary*; or
  - does not have uniform professional endorsement; or
  - is experimental or investigational in nature.
- *treatment* which does not have a reasonably favorable prognosis, as determined by us.
- *treatment* provided primarily for cosmetic purposes.

## DENTAL INSURANCE (continued)

- *treatment* received as a result of disease, defect, or *injury* due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit an assault or felony.
- *treatment* of *injury* arising out of, or in the course of, doing any work for pay, profit, or gain, whether on your or a *covered dependent's* job or any other job.
- *treatment* of an intentionally self-inflicted *injury*.
- *treatment* performed outside of the United States of America, other than *emergency dental treatment*. However, for such *emergency dental treatment*, the benefits payable shall not exceed the *allowable charge* for the *treatment* at your employer's principal address (shown in the application for insurance) in the USA.
- *treatment* rendered by a dental clinic or similar clinic that is operated by your or your spouse's employer, labor union, or similar group.
- *treatment* of a provider who is a member of your or your spouse's immediate family.
- *treatment* for which a charge would not have been made in the absence of insurance.
- *treatment* for which you or your *covered dependent* do not have to pay, except when payment of such benefits is required by law and only to the extent required by law.
- *treatment* that has not been both delivered to and accepted by you or your *covered dependent*.
- *orthodontic treatment*, unless such insurance is provided under the list of covered dental services.

### Limited Extension of Benefits After Insurance Ends

If an otherwise non-orthodontic covered dental service is started while you or your *covered dependent* are insured under the *policy* (and after any applicable waiting periods are served), but is completed after the day your or your *covered dependents* insurance ends, we will pay benefits for otherwise covered dental expenses incurred for that service subject to all of the following rules:

- Benefits are not available to you or your *covered dependent* if, on the day after insurance ends, you or your *covered dependent*, obtain, or are eligible to obtain, dental care coverage under any group or governmental plan;
- Benefits are not available to you or your *covered dependent* if insurance ends because any required premium contributions were stopped while still eligible for insurance;
- Benefits are not available for any *treatment* started after the day your or your *covered dependents* insurance ends;
- Benefits are payable only in the amount that would have been payable, and subject to the same provisions that would have applied, had your or your covered dependent's insurance still been in effect;
- Benefits are payable only if the *treatment* is completed within 31 days after the date your or your *covered dependents* insurance ends, unless you or your *covered dependent* become injured or sick after the *treatment* is started and that is the only reason the *treatment* could not be completed during those 31 days. Then, benefits are payable only if the *treatment* is completed before the earlier of:
  - the date 31 days after the first date the *injury* or sickness no longer prevents the *treatment* from

## DENTAL INSURANCE (continued)

being completed; or

- the date 91 days after the date your or your *covered dependents* insurance ends;
- We will not pay any benefits for treatment which is completed on or after the first date you or your *covered dependent* obtain, or are eligible to obtain dental care coverage under any group or governmental plan.

## COORDINATION OF BENEFITS

### Applicability

The Coordination of Benefits (COB) provision applies when you or a *covered dependent* has dental care coverage under more than one *plan*. *Plan* is defined below. All of the benefits provided under the *policy* are subject to *this provision*.

### Definitions

*Allowable expense* means a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any *plan* covering the person. When a *plan* provides benefits in the form of services, the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense that is not covered by any *plan* covering the person is not an *allowable expense*. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging you or a *covered dependent* is not an *allowable expense*.

The following are examples of expenses that are not *allowable expenses*:

- If you or a *covered dependent* is covered by 2 or more *plans* that compute their benefit payments on the basis of:
  - dentally necessary, usual and customary fees; or
  - relative-value, schedule-reimbursement methodology; or
  - other similar reimbursement methodology,

any amount in excess of the highest reimbursement amount for a specific benefit is not an *allowable expenses*.

- If you or a *covered dependent* is covered by 2 or more *plans* that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *allowable expenses*.
- If you or a *covered dependent* is covered by one *plan* that calculates its benefits or services on the basis of:
  - dentally necessary, usual and customary fees; or
  - relative-value, schedule-reimbursement methodology; or
  - other similar reimbursement methodology; and
  - another plan that provides its benefits or services on the basis of negotiated fees;

the *primary plan's* payment arrangement will be the *allowable expenses* for all *plans*.

However, if the provider has contracted with the *secondary plan* to provide:

- the benefit or service for a specific negotiated fee; or
- payment amount that is different than the *primary plan's* payment arrangement; and
- if the provider's contract permits,

the negotiated fee or payment shall be the *allowable expenses* used by the *secondary plan* to determine its benefits.

- The amount of any benefit reduction by the *primary plan* because you or a *covered dependent* has failed to comply with the *plan* provisions is not an *allowable expense*. Examples of these types of *plan* provisions include:

## COORDINATION OF BENEFITS (continued)

- any required second opinion,
- some form of predetermination of *treatment*, and
- preferred provider arrangements.

*Birthday* refers only to month and day in a calendar year and does not include the year of birth.

*Claim* means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

- services (including supplies); or
- payment for all or a portion of the expenses incurred; or
- combination of services or expenses shown above; or
- indemnification.

*Claim period* means a calendar year. A *claim period* will not start before a person's effective date of insurance under *this plan* nor extend beyond the last day the person is covered under *this plan*.

*Closed-panel plan* is a *plan* that provides dental care benefits to you or a *covered dependent* primarily in the form of services through a panel of providers that

- have contracted with or are employed by the *plan*, and
- excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

*Consolidated Omnibus Budget Reconciliation Act of 1985* or "COBRA" means coverage provided under a right of continuation compliant with federal law.

*Custodial parent* is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

*Medicaid* means Title XIX of the Social Security Act of 1965 as amended.

*Plan* means any of the following that provides benefits or services for dental care or *treatment*:

- Group and non-group insurance contracts, dental service prepayment coverage, or subscriber plans;
- Dental Maintenance Organization (DMO) contracts or Health Maintenance Organization (HMO) contracts;
- Closed-panel plans or other forms of group or group-type coverage, as permitted by law or regulation (whether insured or uninsured);
- Dental benefits under group or individual automobile contracts, as permitted by state law or regulation; and
- Medicare or any other federal governmental plan, as permitted by law.

If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same *plan* and there is no COB among those separate contracts.

*Plan* does not include any of the following:

## COORDINATION OF BENEFITS (continued)

- Hospital indemnity coverage or other fixed indemnity coverage;
- Accident-only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage, as defined by state law;
- School accident-type coverage;
- Benefits for non-dental services provided under long-term care coverage;
- Medicare supplement coverage;
- A state plan under Medicaid; or
- Coverage under a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

Each contract for coverage shown above is a separate *plan*. If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

*Primary plan* means the *plan* that pays or provides its benefits first, according to its terms of coverage and without regard to benefits under any other *plan*.

Except as provided below, a *plan* that does not contain a COB provision that is consistent with *this provision* is always the *primary plan* unless the provisions of both *plans* state that the *plan* with a COB provision is the *primary plan*.

Coverage that is obtained by virtue of membership in a group that is:

- designed to supplement a part of a basic package of benefits, and
- provides that this supplementary coverage,

shall be excess to any other parts of the *plan* provided by the *policyholder*.

An example of this type of situation is insurance-type coverage that is written in connection with a *closed-panel plan* to provide out-of-network benefits.

*Secondary plan* means the *plan* that determines its benefits after those of another *plan* and may reduce the benefits it pays so that all *plan* benefits do not exceed 100% of the total *allowable expenses* incurred by you or a covered dependent during the *claim period*.

*This plan* means the benefits provided by the *policy*. When there are more than two *plans*, *this plan* may be a *primary plan* to one or more other *plans*, and may be a *secondary plan* to a different *plan(s)*.

This provision means the provision for coordination between the benefits of *this plan* and other *plans*.

Other definitions that may apply to *this provision* appear in the Definitions provisions of this *policy*.

## COORDINATION OF BENEFITS (continued)

### Order of Benefit Determination

When you or a *covered dependent* has dental care coverage under more than one *plan*, each *plan* determines its order of benefits using the first of the following rules that apply:

#### 1. Non-Dependent or Dependent

The *plan* that covers the person other than as a dependent, e.g., as an employee, member, policyholder, subscriber or retiree is the *primary plan* and the *plan* that covers the person as a dependent is the *secondary plan*.

However, if

- you or a *covered dependent* is a Medicare beneficiary and,
- as a result of federal law,
  - Medicare is secondary to the *plan* covering the person as a dependent; and
  - primary to the *plan* covering the person as other than a dependent (e.g., a retired employee);

then, the order of benefits between the two *plans* is reversed so that

- the *plan* covering the person as an employee, member, policyholder, subscriber or retiree is the *secondary plan*, and
- the other *plan* is the *primary plan*.

#### 2. Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, when a dependent child is covered by more than one *plan* the order of benefits is determined as follows:

- For a *covered dependent* child whose parents are married or are living together, whether or not they have ever been married:
  - The *primary plan* is the *plan* of the parent whose *birthday* falls earlier in the calendar year; or
  - If both parents have the same *birthday*, the *primary plan* is the *plan* that has covered the parent the longest.
- For a *covered dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
  - If a court decree states that one of the parents is responsible for the dependent child's dental care expenses or dental care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is the *primary plan*. This rule applies to *plan* years commencing after the *plan* is given notice of the court decree;
  - If a court decree states that both parents are responsible for the *covered dependent* child's dental care expenses or dental care coverage, benefits will be determined according to the *birthday* rule described above;
  - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the *covered dependent* child, benefits will be determined according to the *birthday* rule described above; or
  - If there is no court decree allocating responsibility for the dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:
    - The plan covering the custodial parent;

## COORDINATION OF BENEFITS (continued)

- The plan covering the spouse of the custodial parent;
- The plan covering the non-custodial parent; and then
- The plan covering the spouse of the non-custodial parent.
  - For a *covered dependent* child covered under more than one *plan* of individuals who are the parents of the child, benefits will be determined according to the *birthday* and longer or shorter rules, as if those individuals were the parents of the child.

### 3. Active Employee or Retired or Laid-off Employee

- The *primary plan* is the *plan* that covers a person as an active employee, e.g., an employee who is neither laid off nor retired.
- The *secondary plan* is the *plan* covering that same person as a retired or laid-off employee.

The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee.

If the other *plan* does not have this rule, and therefore, the *plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rules described in item 1 above can determine the order of benefits.

### 4. COBRA or State Continuation Coverage

If you or your *covered dependent* has coverage provided under

- COBRA, or
- continuation provided by state or other federal continuation law, and

is covered under another *plan*, then

- the *primary plan* is the *plan* covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree, and
- the *secondary plan* is the plan providing coverage under COBRA, state or other federal continuation law.

If the other *plan* does not have this rule, and therefore, the *plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the *birthday* rule can determine the order of benefits.

### 5. Longer or Shorter Length of Coverage

- The *primary plan* is the *plan* that covered the person as an employee, member, policyholder, subscriber or retiree longer.
- The *secondary plan* is the *plan* that covered the person the shorter length of time.

If none of the rules described above determine the order of benefits, the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan*. In addition, *this plan* will not pay more than it would have paid had it been the *primary plan*.

## Effect on Benefits

When *this plan* is the *secondary plan*, it may reduce its benefits so that the total benefits paid or provided by all *plans* during a *claim period* are not more than the total *allowable expenses*.

In determining the amount to be paid for any *claim*, the *secondary plan* will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any *allowable expense* under its *plan* that is unpaid by the *primary plan*. The *secondary plan* may then reduce its payment by the amount so that, when combined with the amount paid by the *primary plan*, the total benefits paid or provided by all *plans* for the *claim* do not exceed the total *allowable expense* for that *claim*.

In addition, the *secondary plan* shall credit to its *plan* deductible any amounts it would have credited to its



## COORDINATION OF BENEFITS (continued)

deductible in the absence of other dental care coverage.

If you or a *covered dependent* is enrolled in two or more *closed-panel plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and other *closed-panel plans*.

If you or a *covered dependent* is covered by more than one dental benefit *plan*, you should file all your claims with each *plan*.

### Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply the rules of *this provision* and to determine benefits payable under *this plan* and other *plans*. We may get the facts we need from or give them to other organizations or persons for the purpose of:

- applying the rules of *this provision*; and
- determining benefits payable under this *plan* and other *plans* covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under *this plan* must give us any facts we need to apply those rules and determine benefits payable.

### Facility of Payment

A payment made under another *plan* may include an amount that should have been paid under *this plan*. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under *this plan*. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

### Right Of Recovery

If we pay more than we should have paid under *this provision*, we may recover the excess from one or more of the persons it has paid or for whom it has paid. Or, we may recover the excess from any other person or organization that may be responsible for the benefits or services provided for you or a *covered dependent*. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

## CLAIM PROVISIONS

### Payment of Benefits

We will pay benefits when we receive all the required proof of covered loss.

### To Whom Payable

We will pay dental benefits directly to the providers of dental services for treatment of you or your covered dependents, if you have assigned your benefits to the providers. We will pay dental benefits to you, if you have not assigned your benefits to the providers. After your death, we have the option to pay any benefits due to your spouse, to the providers of the treatment, or to your estate.

### Authority

We have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the Policy. All determinations and interpretations made by us are conclusive and binding on all parties.

### Filing a Claim

1. Your *dentist* should send us notice of claim for dental *treatment*. We must have written notice of any insured loss within 30 days after it occurs, or as soon as reasonably possible. You can send the notice to our *home office*, one of our regional claims offices, or to one of our agents. We need enough information to identify you as a *covered person*. If charges for dental *treatment* are expected to be \$300 or more, you can receive an estimate of benefits payable before *treatment* begins by following the procedures outlined in the Pre-estimate provision.
2. Within 15 days after the date of the notice, we will send you certain claim forms. The forms must be completed and sent to our *home office* or one of our regional claims offices. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.
3. The time limit for filing a claim is 90 days after the date of the loss.
4. To decide our liability, we may require:
  - itemized bills,
  - proof of benefits from other sources, and
  - proof that you have applied for all benefits from other sources, and that you have furnished any proof required to get them.

For dental expenses, we may require additional information to determine our liability, including, but not limited to:

- a complete dental charting indicating extractions, missing teeth, fillings, prosthesis, periodontal pocket depths, orthodontic relationship and the dates work was previously performed, and
- preoperative x-rays, study models, laboratory and/or hospital reports.

We will ask you to authorize the sources of medical and dental services to release your medical information. If you do not furnish any required information or authorize its release, we will not pay benefits.

If it is not reasonably possible to give proof on time, we will not deny or reduce your claim if you give us proof as soon as reasonably possible.

### Physical Exam

We may ask you to be examined as often as we require at any time we choose. We will pay for any exam we require.

## **CLAIMS PROVISIONS (continued)**

### **Limit on Legal Action**

No action at law or in equity may be brought against the policy until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations in your state has expired, but, in any case, not after 6 years from the date of loss.

### **Incontestability**

The validity of the policy cannot be contested after it has been in force for 2 years, except if premiums are not paid.

Any statement made by the policyholder or a covered person will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the covered person or the beneficiary.

No statement, except fraudulent misstatement, made by a covered person about insurability will be used to deny a claim for a loss incurred or disability starting after coverage has been in effect for 2 years.

No claim for loss starting 2 or more years after the covered persons effective date may be reduced or denied because a disease or physical condition existed before the persons effective date, unless the condition was specifically excluded by a provision in effect on the date of loss

### **Overpayment**

If a benefit is paid under the policy and it is later shown that a lesser amount should have been paid, we will be entitled to a refund of the excess amount from the provider or you.

### **Subrogation Rights**

In the event of any payments for benefits provided to you or a covered dependent under the policy, we, to the extent of our payments, will be subrogated to all rights of recovery you or your dependent have against any person or organization. You or your dependent will execute and deliver any instruments and papers as may be required and do whatever else is necessary to secure those rights to us and will do nothing after loss to prejudice our rights. If we are precluded from exercising our Subrogation Rights, we may exercise our Right to Reimbursement.

### **Right to Reimbursement**

If you or a covered dependent: (a) seek legal recourse (whether by suit, settlement, judgment or otherwise) against any person or organization; and (b) recover payment, in whole or in part, from any such person or organization for the benefits previously paid under the policy, then you or your dependent must reimburse us for all payments made under the policy for which you have received reimbursement.

Any payments made prior to determination of work-related injury, will be reimbursed upon determination of such payment.

However, the reimbursement will not exceed: (a) the amount of the benefit payments made under the policy for which payment is recovered from any person or organization; or (b) the amount recovered from any such person or organization as payment for the same covered dental expenses.

You or your covered dependents are not obligated by this provision to seek legal action against any person or organization for which benefits have been paid under the policy.

## **GENERAL PROVISIONS**

### **Entire Contract**

The policy and the policyholders application attached to it are the entire contract. Any statement made by you or the policyholder is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

### **Errors**

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary, but not beyond 3 years before the date the error was found. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

### **Misstatements**

If any information about a person is misstated, the facts will determine whether insurance is in effect and in what amount. We will equitably adjust the premium.

### **Individual Certificates**

We will send certificates to the policyholder to give to each covered person. The certificate will state the insurance to which the person is entitled. It does not change the provisions of the policy.

### **Workers Compensation**

The policy is not in place of, and does not affect any states requirements for coverage by Workers Compensation insurance.

### **Agency**

Neither the policyholder, any employer, any associated company, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

## **ENDORSEMENT**

Effective on and after its effective date, the Certificate is endorsed as follows:

At the request of the policyholder, for dependent dental insurance, the term spouse shall also mean a domestic partner. A domestic partner is defined in the policyholders Declaration of Domestic Partnership agreement.

## HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice applies to our HIPAA covered healthcare plans, including dental, vision, cancer only, hospital indemnity, and critical illness.

### **I. Our Commitment**

Union Security Insurance Company, and the prepaid dental companies\* are committed to protecting the personal information entrusted to us by our customers. The trust you place in us when you share your personal information is a responsibility we take very seriously and is the cornerstone of how we conduct our business

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

### **II. Our Use and Disclosure of Your PHI**

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

Other examples of possible disclosures for purposes of healthcare operations include:

- Underwriting our risk and determining rates and premiums for your healthcare plan;
- Determining your eligibility for benefits;
- Reviewing the competence and qualifications of healthcare providers;
- Conducting or arranging for review, legal services, and auditing functions, including fraud and abuse detection and compliance;
- Business planning and development;
- Business management and general administrative duties such as cost-management, customer service, and resolution of internal grievances;
- Other administrative purposes.

We can also make disclosures under the following circumstances without your permission:

- As required by law, including response to court and administrative orders, or to report information about suspected criminal activity;
- To report abuse, neglect, or domestic violence;
- To authorities that monitor our compliance with these privacy requirements;

- To coroners, medical examiners, and funeral directors;
- For research and public health activities, such as disease and vital statistic reporting;
- To avert a serious threat to health or safety;
- To the military, certain federal officials for national security activities, and to correctional institutions;
- To the entity sponsoring your group healthcare plan but only for purposes of enrollment, disenrollment, and eligibility, or for the purpose of giving the plan sponsor summary information when necessary to help make decisions regarding changes to the plan. If the plan sponsor has certified that its plan documents have been amended to include certain privacy provisions, we may also disclose protected health information to the plan sponsor to carry out plan administration functions that the plan sponsor performs on behalf of the plan;
- To a spouse, family member, or other personal representative if they can show they are assisting in your care or payment of your care and then, without an authorization, only basic information about the status or payment of a claim.

Unless you give us written authorization, we cannot use or disclose your PHI for any reason except as otherwise described in this notice. including uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute the sale of protected health information. We are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes. You may revoke your written authorization at any time by writing us at the address indicated at the end of this notice.

### III. Your Individual Rights

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

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

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

#### IV. Who to Contact for Questions and Complaints

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

Mailing Address:	Sun Life Financial Privacy Officer P.O. Box 419052 Kansas City, MO 64141-6052
Telephone:	(800) 733-7879
Email:	SLF_US_Privacy@sunlife.com
Web Site:	<a href="http://www.sunlife.com/us">www.sunlife.com/us</a>

#### V. Organizations Covered by This Notice

This notice applies to the privacy practices of the organizations referenced below. These organizations may share your PHI with each other as needed for payment activities or health care operations relating to the healthcare plans that we provide.

#### VI. Effective Date of This Notice: April 14, 2003

Revised: October 21, 2016

\* In this notice, "we", "us", and "our" refer to Union Security Insurance Company and the following prepaid dental companies: DentiCare of Alabama, Inc., Union Security DentalCare of Georgia, 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., Union Security DentalCare of New Jersey, Inc.

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*Union Security Insurance Company*  
2323 Grand Boulevard  
Kansas City, Missouri 64108-2670

G933

January 1, 2020

## **Group Dental Appeals Process Information Packet**

### **Group Dental Appeals Process Information Packet Union Security Insurance Company**

**CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS THAT WE MAKE ABOUT YOUR DENTAL CARE.**

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

We will send you a copy of this information packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we will also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call our dental claims toll-free number 800.442.7742 to ask for a copy.

At the back of this packet, you will find a form that you can use for your appeal. The Arizona Department of Insurance and Financial Institutions ("Department") developed these forms to help people who want to file a dental care appeal. You are not required to use them. We 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 800.325.2548 or call us at our toll-free number 800.442.7742.

#### **How to Know When You Can Appeal**

When we deny all or a portion of a dental claim, we will notify you of your right to appeal that decision. Your notice may come directly from us or through your treating provider.

#### **Decisions You Can Appeal**

You can appeal the following decisions:

1. We do not pay for a service that you have already received.
2. We deny all or a portion of a dental claim because we determined that an alternate treatment would accomplish a professionally satisfactory result.
3. We deny all or a portion of a dental claim because we determine that it is not covered under your insurance policy, and you believe it is covered.

#### **Decisions You Cannot Appeal**

You cannot appeal the following decisions:

1. You disagree with our decisions as to the amount of "usual and customary charges."
2. You disagree with how we are coordinating benefits when you have dental insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your dental plan deductible.
4. You disagree with the amount of coinsurance or copayments that you have paid.
5. You disagree with our decision to issue or not issue a dental policy to you.
6. You are dissatisfied with any rate increase you may receive under your dental insurance policy.
7. You believe that we have 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 and Financial Institutions, Consumer Affairs Division, 100 N. 15th Avenue, Suite 261, Phoenix, AZ 85007-2630.

## **Who Can File an Appeal?**

Either you or your treating dental 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 us a letter with the same information.

## **Description of the Dental Appeals Process**

The dental appeals process has two levels of appeals.

- Level 1 Formal Appeal
- Level 2 External Independent Dental Review

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

### **APPEALS PROCESS FOR DENIED DENTAL CLAIMS**

#### **Level 1: Formal appeal**

**Your request:** You may request Formal Appeal if: (1) you have dental coverage with us, and (2) we deny all or a portion of a dental claim. You have 2 years from our first denial notice to request Formal Appeal. To help us make a decision on your appeal, you or your provider should also send us information (that you have not already sent us) to show why we should pay the claim. Send your appeal request and information to:

Union Security Insurance Company  
PO Box 2940  
Clinton, IA 52733-2940  
800.442.7742

**Our acknowledgement:** We have 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating dental provider a notice that we got your request.

**Our decision:** We have up to 60 days to decide whether we should change our decision and pay your claim. We will send you and your treating dental provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

**If we deny all or a portion of your dental claim:** You have 4 months to appeal to Level 2.

**If we grant your request:** We will pay the claim and the appeal is over.

**If we refer your case to Level 2:** We may decide to skip Level 1 and send your case straight to an independent reviewer at Level 2.

#### **Level 2: External, Independent Review**

**Your request:** You may appeal to Level 2 only after you have appealed through Level 1. You have 4 months after you receive our Level 1 decision to send us your written request for External Independent Review. Send your request and any more supporting information to:

Union Security Insurance Company  
PO Box 2940  
Clinton, IA 52733-2940  
800.442.7742

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

**The process:** If we deny all or part of your claim for dental services, the denial will be due to contract coverage. This means that the denial is made because we determine that a service is not covered under your insurance policy or because an alternate treatment would accomplish a professionally satisfactory result. For denials based on contract coverage, the Arizona Insurance Department is the independent reviewer.

### Contract Coverage Cases

Within 5 days after receiving your request, we will:

1. Mail a written acknowledgement of your request to the Insurance Director, you and your treating dental 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 our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reason of our decision.

Within 15 days of receiving this information, the Insurance Director must determine if the dental claim is payable, issue a decision, and send a notice to us, you, and your treating dental provider.

**Referral to the Independent Review Organization (“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 you, your treating dental provider, and us. If the IRO has decided that the claim is payable, we will issue payment. If the IRO agrees with our decision to uphold the denial, the appeal is over.

**The decision (contract coverage):** If you disagree with the Insurance Director’s final decision on a coverage issue, you may request a hearing with OAH. If we disagree with the Director’s determination of coverage issues, we 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. §20-2293) 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 dental provider who has your records will provide you or the person you specified with a copy of your dental records.

**Confidentiality:** Dental records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeals process, the relevant portions of your dental records may be disclosed only to people authorized to participate in the review process for the dental claim 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 us 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 us as soon as you get it. You must also give us the address and telephone number where you can be contacted. If the appeal is already at Level 2, 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 decision, you must pursue the dental appeals process before the Insurance Director can investigate a complaint you may have against our company 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 decision of insurers.
5. Review decision 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 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 5<sup>th</sup> business day after being mailed. “Properly addressed” means your last known address.

**Union Security Insurance Company**

PO Box 2940

Clinton Iowa 52733-2940

T 800.442.7742

**DENTAL CARE APPEAL REQUEST**

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

Insured member's name \_\_\_\_\_ Member policy no. \_\_\_\_\_

Name of representative pursuing appeal, if different from above \_\_\_\_\_

Mailing Address \_\_\_\_\_ Phone no. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Type of Denial: Denied Claim \_\_\_\_\_ Denied Service Not Yet Received \_\_\_\_\_

Name of Insurer that denied the claim \_\_\_\_\_

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 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 Arizona Department of Insurance and Financial Institutions Consumer Assistance number 602.364.2499 or 800.325.2548, or call us at our toll-free number 800.442.7742.

**Make sure to attach everything that shows why you believe your insurer should cover your claim, including:**

☐ Dental Records    ☐ Supporting Documentation (letter from your dentist, brochures, notes, receipts, etc.)

SIGNATURE OF INSURED OR AUTHORIZED REPRESENTATIVE

DATE

2323 Grand Boulevard  
Kansas City, MO 64108

## SAMPLE FULFILLMENT PACKET FOR FREEDOM ADVANCE

802 - G933  
ARIZONA RETIREE  
123 CHERRY ST  
PHOENIX, AZ 85005

G933 0020 E6 FNAE7B FREEDOM ADVANCE DHP PASSIVE AZ 20200101 12/13/2019



Thank you for selecting Sun Life\* for your dental product. We are pleased to provide you with the attached dental identification cards. If you have previously received cards, please replace your current ID cards with the attached cards.

Register today for a Sun Life account at [www.sunlife.com/account](http://www.sunlife.com/account). A Sun Life account provides you with the ability to:

- Download your ID card
- View benefit and claims information
- Find a dentist

### Go Mobile!

Scan the code on the right (or go to [www.sunlife.com/mobileapps](http://www.sunlife.com/mobileapps)) to download our mobile app, **Benefit Tools**, to access many of the same resources as your Sun Life account.



If you have any questions, please call the toll-free number listed on your ID card.

You always have the freedom to choose any dentists with your dental plan. When using an in-network dentist, you may save on out-of-pocket costs.

\*Insurance products are underwritten by Union Security Insurance Company (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (Wellesley Hills, MA).

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Sun Life's dental networks include dentists contracted with Dental Health Alliance, L.L.C.® (D.H.A.®) and dentists under access arrangements with other dental networks.

BATCH  
GF

## Membership Cards



GROUP ID NUMBER  
G933

ISSUED TO  
ARIZONA STATE RETIREMENT  
SYSTEM

MEMBER SIGNATURE

Insurance products are underwritten by Union Security Insurance Company (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (Wellesley Hills, MA).



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**Assurant Dental Network®**  
(Includes Aetna Dental® Administrators)

To locate a dentist in your area – visit [www.sunlife.com/findadentist](http://www.sunlife.com/findadentist). Input your Group ID and hit search.

**Dental Coverage:** Benefits are subject to group provisions including deductibles, coinsurance and coordination of benefits. This card is NOT a guarantee of payment. Please call to verify benefits. If services are to exceed \$300, please submit a pre- determination.

**Vision Service Plan (VSP):** Present this card to obtain discounts from VSP providers. To locate a provider, call 800- 877- 7195 or visit [www.vsp.com](http://www.vsp.com). This is not insurance.

**For Benefit and Claim Information:**

Sun Life  
P.O. Box 2940, Clinton, IA 52733

**Electronic Claims:** Payor 70408  
800- 442- 7742

**Assurant Dental Network®**  
(Includes Aetna Dental® Administrators)

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## HIPAA Notice of Privacy Practices

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

This Notice applies to our HIPAA covered dental and vision plans.

### Our Commitment

Union Security Insurance Company, Union Security Life Insurance Company of New York, and the prepaid dental companies\* are committed to protecting the personal information entrusted to us by our customers. The trust you place in us when you share your personal information is a responsibility we take very seriously and is the cornerstone of how we conduct our business.

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

### Our Use and Disclosure of Your PHI

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

Other examples of possible disclosures for purposes of healthcare operations include:

- Underwriting our risk and determining rates and premiums for your healthcare plan;
- Determining your eligibility for benefits;
- Reviewing the competence and qualifications of healthcare providers;
- Conducting or arranging for review, legal services, and auditing functions, including fraud and abuse detection and compliance;
- Business planning and development;

- Business management and general administrative duties such as cost-management, customer service, and resolution of internal grievances;
- Other administrative purposes.
- We can also make disclosures under the following circumstances without your permission:
- As required by law, including response to court and administrative orders, or to report information about suspected criminal activity;
- To report abuse, neglect, or domestic violence;
- To authorities that monitor our compliance with these privacy requirements;
- To coroners, medical examiners, and funeral directors;
- For research and public health activities, such as disease and vital statistic reporting;
- To avert a serious threat to health or safety;
- To the military, certain federal officials for national security activities, and to correctional institutions;
- To the entity sponsoring your group healthcare plan but only for purposes of enrollment, disenrollment, eligibility or for the purpose of giving the plan sponsor summary information when necessary to help make decisions regarding changes to the plan. If the plan sponsor has certified that its plan documents have been amended to include certain privacy provisions, we may also disclose protected health information to the plan sponsor to carry out plan administration functions that the plan sponsor performs on behalf of the plan;
- To a spouse, family member, or other personal representative if they can show they are assisting in your care or payment of your care and then, without an authorization, only basic information about the status or payment of a claim.

**Unless you give us written authorization, we cannot use or disclose your PHI for any reason except as otherwise described in this notice, including uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute the sale of protected health information. We are prohibited from using or disclosing your protected health**

Insurance products are underwritten by Union Security Insurance Company (USIC) (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (SLOC) (Wellesley Hills, MA) in all states except New York. Prepaid dental products are provided by USIC and are administered by SLOC, and are provided by prepaid dental companies affiliated with SLOC in certain states except New York. Prepaid dental companies are Denticare of Alabama, Inc., United Dental Care of Arizona, Inc., UDC Dental California, Inc., United Dental Care of Colorado, Inc., Union Security DentalCare of Georgia, Inc., United Dental Care of Michigan, Inc., United Dental Care of Missouri, Inc., Union Security DentalCare of New Jersey, Inc., United Dental Care of New Mexico, Inc., UDC Ohio, Inc., United Dental Care of Texas, Inc., and United Dental Care of Utah, Inc. In New York, insurance products and prepaid dental products are underwritten or provided by Union Security Life Insurance Company of New York (Fayetteville, NY) and administered by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).

information that is genetic information for underwriting purposes. You may revoke your written authorization at any time by writing us at the address indicated at the end of this notice.

### **Your Individual Rights**

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

- **To Restrict our Use or Disclosure.** You have the right to ask us to limit our use or disclosure of your PHI. While we will consider your request, we are not legally required to agree to the additional restrictions. If we do agree to all or part of your request, we will inform you in writing. We cannot agree to limit any use and disclosure of your PHI if the use or disclosure is required by law.
- **To Access your PHI.** You have the right to view and/or copy your PHI at any time by contacting us. If you want copies of your PHI, or want your PHI in a special format, we may charge you a fee. You have a right to choose what portions of your PHI you want copied and to have prior notice of copying costs. If for some reason we deny your request for access to your PHI, we will provide a written explanation of why your request was denied and explain how you can appeal the denial.
- **To Amend your PHI.** You have the right to amend your PHI, if you believe it is incomplete or inaccurate. Your request must be in writing, with an explanation of why you feel the information should be amended. If we approve your request to amend your PHI, we will make reasonable efforts to inform others, including people you name, about the amendment to your PHI. We may deny your request for various reasons, for example, if we determine that the information is correct and complete, or if we did not create the information. If we deny your request, we will provide you a written explanation of our decision. We also will explain your rights regarding having your request and our response included with all future disclosures of your PHI.
- **To Obtain an Accounting of our Disclosures.** You have the right to receive a listing from us of all instances in the past six years in which we or our business associates have disclosed your PHI for purposes other than treatment, payment, health care operations, or as authorized by you. The accounting will tell you the date we made the disclosure, the name of the person or entity to whom the disclosure was made, a description of the PHI that was disclosed, and the reason for the disclosure. There may be a charge for accounting disclosures if requested more than once a year.
- **To Request Alternative Communications.** You have the right to ask us to communicate with you about your confidential information by a different method or at another location. We will accommodate all reasonable requests.
- **To Be Notified of a Breach:** You will be notified in the event that unsecured protected health information is compromised.
- **To Receive Notice.** You are entitled to receive a copy of this notice that outlines our HIPAA privacy practices. We reserve the right to change these

practices and the terms of this notice at any time. We will not make any material changes to our privacy practices without first sending you a revised notice. If you receive this notice on our web site or by electronic mail, you may request a paper copy.

### **Who to Contact for Questions and Complaints**

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

**Mailing Address:** Sun Life Financial  
Privacy Officer  
P.O. Box 419052  
Kansas City, MO 64141-6052

**Telephone:** 800.733.7879

**Email:** SLF\_US\_Privacy@sunlife.com

**Web Site:** [www.sunlife.com/us](http://www.sunlife.com/us)

### **For New York business:**

**Mailing Address:** Union Security Life Insurance  
Company of New York  
Privacy Officer  
Administered by:  
Sun Life Financial  
P.O. Box 419052  
Kansas City, MO 64141-6052

**Telephone:** 888.901.6377

**Email:** SLF\_US\_Privacy@sunlife.com

### **Organizations Covered by This Notice**

This notice applies to the privacy practices of the organizations referenced below. These organizations may share your PHI with each other as needed for payment activities or health care operations relating to the healthcare plans that we provide.

**Effective Date of This Notice:** April 14, 2003.

**Revised:** October 21, 2016

\* In this notice, "we," "us," and "our" refer to Union Security Insurance Company, Union Security Life Insurance Company of New York and the following prepaid dental companies: DentiCare of Alabama, Inc., Union Security DentalCare of Georgia, 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., Union Security DentalCare of New Jersey, Inc.

# **Group Dental Benefits**

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**Arizona State Retirement  
System**

**Advance Plan, Amended  
01/01/2020**

**G933**

**CERTIFICATE OF  
GROUP INSURANCE**

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**Union Security Insurance Company** certifies that the insurance stated in this Certificate became effective on the Effective Date shown in your Schedule. This Certificate is subject to the provisions of the below numbered *policy* issued by Union Security Insurance Company to the *policyholder*.

Policyholder: Arizona State Retirement System

Policy Number: G933

This Certificate replaces any and all Certificates and Certificate Endorsements, if any, issued to you under the *policy*.

A handwritten signature in black ink, appearing to read "Joe Roberts". The signature is fluid and cursive, with a large initial "J" and a long horizontal stroke at the end.

President and Chief Executive Officer

## SCHEDULE

### Eligible Persons

To be eligible for insurance, a person must be a member of an Eligible Class. The person must also complete a period of continuous service (Service Requirement) with the *policyholder* (or any *associated company*).

### Eligible Class:

For employee insurance - Each retired employee of the policyholder or an associated company.

For dependent insurance - Each person eligible for employee insurance.

**Associated Companies:** None

**Present Service Requirement:** None

**Future Service Requirement:** None

### Entry Date

Insurance will take effect on the later of (i) the date shown below, or (ii) the first of the month occurring on or after the day all eligibility requirements are met.

### Effective Date of Insurance

January 1, 2003 (Subject to Entry Date)

## SCHEDULE

### Dental Insurance

#### Deductible Amount

Individual Deductible Amount Per <i>Policy Year</i>	\$ 50
Maximum Family Deductible per <i>policy year</i>	3 persons
The Individual Deductible does not apply to Type I Dental Services	

#### Coinsurance Percentages

COINSURANCE PERCENTAGE PER PERSON PER INDIVIDUAL BENEFIT YEAR	DENTAL SERVICES		
	TYPE I	TYPE II	TYPE III
DURING THE 1 <sup>ST</sup> YEAR	80%	80%	25%
DURING THE 2 <sup>ND</sup> YEAR	80%	80%	50%
THEREAFTER:	80%	80%	50%

#### Benefit Maximums:

<i>Policy Year</i> Maximum	\$ 2500
----------------------------	---------

Covered dental expenses incurred for Type I Dental Services will not be applied to the Policy Year Maximum.

Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the Listing of Covered Dental Services. However, benefits will be payable based on the most current dental terminology.

#### Vision Plan

You and your *covered dependents* are eligible for discounted vision services. The discounted vision services are provided through a third party vendor and are not covered under an insured plan. The discounted vision services offered include discounts on eye exams, prescription glasses, and services related to prescription contact lenses.

#### Plan Changes

You may change your plan of insurance only during the annual enrollment period agreed upon by the *policyholder* and us, unless you undergo a change in family status. A plan change made during the annual enrollment period will take effect on the next following *policy* anniversary.

You may change your plan within 31 days of a change in family status. The effective date of the change will be the Entry Date occurring on or after the date of the request.

A "change in family status" means your marriage or divorce, the birth or adoption of your child, the death of your spouse or child, the termination of employment of your spouse.

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## GENERAL DEFINITIONS

These terms have the meanings shown here when *italicized*. The pronouns we, us, our, you, and your are not *italicized*.

*Associated company* means any company shown in the *policy* which is owned by or affiliated with the *policyholder*.

*Contributory* means you pay part or all of the premium.

*Covered dependent* means an *eligible dependent* who is insured under the *policy*.

*Covered person* means an eligible employee or member of the *policyholder*, or an *associated company* who has become insured for a coverage.

*Doctor* means a person, other than you, acting within the scope of his or her license to practice medicine and perform surgery.

*Eligible class* means a class of persons eligible for insurance under the *policy*. This class is based on employment or membership in a group.

*Home office* means our office in Kansas City, Missouri.

*Injury* means accidental bodily *injury*. It does not mean intentionally self-inflicted *injury* while sane or insane.

*No-fault motor vehicle coverage* means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident that occurs.

*Policy* means the group *policy* issued by us to the *policyholder* that describes the benefits for which you may be eligible.

*Policyholder* means the entity to whom the *policy* is issued.

*Proof of good health* means evidence acceptable to us of the good health of a person.

We, us and our mean Union Security Insurance Company.

You and your mean an employee or member of the *policyholder* or an *associated company* who has met all the eligibility requirements for a coverage.

## DEFINITIONS FOR DENTAL INSURANCE

*Accidental non-chewing injury* means an *injury* (other than a chewing injury) sustained while insured under the *policy*, which is caused solely and exclusively by an accident which could not be predicted in advance, and which could not be avoided. A chewing injury is any *injury* which occurs during the act of biting or chewing, regardless of whether the *injury* is caused by biting or chewing food, biting on a foreign object not expected to be a normal constituent of food, parafunctional or abnormal habits such as (but not limited to) chewing on eyeglass frames or pencils, biting down on a suddenly dislodged or loose dental appliance, or biting or chewing on any other object for any other reason.

*Allowable charge* means a charge that is based on the general level of charges made by other providers in the area for like *treatment*. Our determination of what is an *allowable charge* is final for the purpose of determining benefits payable under the *policy*.

*Benefit year* means a period of 12 consecutive months, which begins on the date you become insured under the *policy*. Subsequent *benefit years* begin on each succeeding anniversary of the date you became insured under the *policy*.

*Dental hygienist* means an individual who is licensed to practice dental hygiene and acting under the supervision of a *dentist* within the scope of that license in treating the dental condition.

*Dental insurance* means the group dental insurance under the *policy* issued by us to the *policyholder*.

*Dentally necessary and dental necessity* mean a service or *treatment* which is appropriate with the diagnosis and which is in accordance with accepted dental standards. The service or *treatment* must be essential for the care of the teeth and supporting tissues.

*Dental treatment plan* means the *dentist's* report of recommended *treatment* which contains:

- a list of the charges and dental procedures required for the *dentally necessary* care;
- any supporting pre-operative x-rays; and
- any other appropriate diagnostic materials required by us.

*Dentist* means an individual who is licensed to practice dentistry and acting within the scope of that license in treating the dental condition.

*Denturist* means an individual who is licensed to make dentures and acting within the scope of that license in treating the dental condition.

*Emergency dental treatment* means any *dentally necessary treatment* that is rendered as the direct result of unforeseen events or circumstances, which require prompt attention.

*Functioning natural tooth* means a *natural tooth* which is performing its normal role in the chewing process in the person's upper or lower arch and which is opposed in the person's other arch by another *natural tooth* or prosthetic replacement.

*Immediate family* means a person who is related to you or your spouse in any of the following ways: parent, spouse, child, brother, sister, or grandparent.

*Medicare* means a portion of Title XVIII of the United States Social Security Act of 1965, as amended.

*Natural tooth* means any tooth or part of a tooth that is organic and formed by the natural development of the body. Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

*Orthodontic treatment* means the corrective movement of teeth through the bone by means of an active appliance to correct a handicapping malocclusion (a malocclusion severely interfering with a persons ability to

## DEFINITIONS FOR DENTAL INSURANCE (continued)

chew food) of the mouth. We will make the determination of the severity of the malocclusion.

*Other group dental expense coverage* means:

- Any other group *policy* providing benefits for dental expenses; or
- Any plan providing dental expense benefits (whether through a dental services organization or other party providing prepaid health or related services) which is arranged through any employer or through direct contact with persons eligible for that plan.

*Policy year* means the period of time which begins on the *policy* anniversary date of each calendar year and ends on the day before the next following yearly *policy* anniversary date. The first *policy year* begins on the *policy* effective date. The last *policy year* ends on the day *dental insurance* under the *policy* ends.

*Sound tooth* means a *natural tooth* that is fully restored to function, does not have any decay, is not more susceptible to injury than a virgin tooth, and is without periodontal disease.

*Treatment* means any dental consultation, service, supply, or procedure that is needed for the care of the teeth and supporting tissues.

## ELIGIBILITY AND TERMINATION PROVISIONS FOR YOU

### When Your Insurance Ends

Your insurance will end on the date:

- the *policy* ends;
- the *policy* is changed to end the insurance for your *eligible class*;
- you are no longer in an *eligible class*;
- a required contribution was not paid; or
- you become covered under an optional dental plan, which is sponsored by your employer, or the *policyholder*, or an *associated company* and provided through a Dental Maintenance Organization.

## ELIGIBILITY AND TERMINATION PROVISIONS FOR DEPENDENTS

### Eligible Dependents

Your *eligible dependents* are:

- your lawful spouse, and
- your children who are less than age 26.

Children" include any adopted children. A child will be considered adopted on the date of placement in your home. Stepchildren and foster children are also included if they depend on you for support and maintenance. "Children" also include any children for whom you are the legal guardian, who reside with you on a permanent basis and depend on you for support and maintenance.

An *eligible dependent* will not include any person who is a member of an *eligible class*. An *eligible dependent* may not be covered by more than 1 *covered person*.

### Dependent Effective Date

You must apply for dependent insurance on a form acceptable to us. You must also agree to pay your share of the premium.

- If you apply before the dependent becomes eligible, dependent insurance will take effect on the Entry Date shown in the Schedule in the *policy*.
- If you apply on the date the dependent becomes eligible, or within 31 days after that, dependent insurance will take effect on the Entry Date occurring on or after the date of your application.
- If you apply more than 31 days after the date the dependent becomes eligible or after dependent insurance ended because the premium was not paid, then application must be made during an annual enrollment period. Dependent insurance will take effect on the *policy* anniversary occurring on or after the date of application.

### Exception to Dependent Effective Date

Dependent insurance will not take effect until your insurance for the same coverage under the policy takes effect.

If an *eligible dependent* is in a hospital or similar facility on the day insurance would otherwise take effect, it will not take effect until the day after the *eligible dependent* leaves the hospital or similar facility. This exception does not apply to a child born while dependent insurance is in effect.

### When Dependent Insurance Ends

A dependent's insurance will end on the earliest of:

- the day the *policy* ends;
- the day the *policy* is changed to end dependent insurance;
- the last day of the month in which that dependent is no longer eligible;
- the day your insurance for the same coverage under the *policy* ends;
- the day a required contribution for dependent insurance was not paid; or

## ELIGIBILITY AND TERMINATION PROVISIONS FOR DEPENDENTS (continued)

- the day the dependent becomes covered under an optional dental plan which is sponsored by your employer, or the *policyholder*, or an *associated company* and provided through a Dental Maintenance Organization.

### SPECIAL DEPENDENT INSURANCE CONTINUANCE PROVISIONS

As specified below, dependent *dental insurance* may continue, subject to the provisions that describe when insurance ends, and all other terms and conditions of the *policy*. Premiums are required for any coverage continued.

#### Physically Handicapped or Mentally Retarded Dependent Children

Dependent *dental insurance* for an *eligible dependent* child will continue beyond the date a child attains an age limit, if, on that date, he or she:

- is unable to earn a living because of physical handicap or mental retardation; and
- is chiefly dependent upon you for support and maintenance.

We must receive proof of the above within 120 days after the child attains the age limit and each year after that, beginning 2 years after the child attains the age limit. There will be no increase in premium for this continued coverage.

Dependent *dental insurance* will end when the child is able to earn a living or is no longer dependent on you for support and maintenance.



## **SPECIAL FEDERAL CONTINUANCE PROVISIONS**

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered dependents may have the right to continue dental insurance coverage beyond the date insurance would otherwise terminate. You should contact the policyholder concerning your right to continue coverage.

## DENTAL INSURANCE

### Insurance Provided

We will pay benefits for covered dental expenses identified in the *policy* when incurred by you or a *covered dependent*, while covered under the *policy*. We will pay the coinsurance percentage shown in the Schedule after you or a *covered dependent* have satisfied any deductible required for the *policy year*, subject to all the terms and conditions of the *policy*.

Covered dental expenses will only include *treatment* provided to you or a *covered dependent* for which, as outlined in the Listing of Covered Dental Services provision, the date started and the date completed occur while the person is insured under the *policy*. No payment will be made for a program of dental *treatment* already in progress on the effective date of a person's insurance. No payment will be made for dental *treatment* completed after your or a *covered dependents* insurance under the *policy* ends, except as stated in the Limited Extension of Benefits After Insurance Ends provision.

### Deductible

The deductible is the amount shown in the Schedule and will be applied to each type of dental services as indicated in the Schedule. The deductible is the amount of covered dental expenses that you and each *covered dependent* must incur in a *policy year* before we will pay benefits. When covered dental expenses equal to the deductible amount have been incurred and submitted to us, the deductible will be satisfied. We will not pay benefits for covered dental expenses applied to the deductible.

If the deductible amount is increased during a *policy year*, further covered dental expenses must be incurred after the date of increase to satisfy the additional deductible for that *policy year*.

The deductible will apply to you and each *covered dependent* separately each *policy year*, . except as stated in the Maximum Family Deductible Section.

### Maximum Family Deductible

The family deductible is shown in the Schedule. It indicates the number of persons in your family unit who must each satisfy an individual deductible in order to satisfy the family deductible. Once that number of persons has satisfied a deductible for a *policy year* , we will consider the deductible to be satisfied for each person in your family unit for that *policy year*. We will pay benefits for covered dental expenses incurred on or after the date the required number of persons has satisfied the deductible amount.

### Policy Year Maximum

The maximum benefit payable to you and each *covered dependent* during a *policy year* is shown in the Schedule. This maximum will apply even if coverage for you or a *covered dependent* ends and starts again within the same *policy year* or if you or a *covered dependent* have been covered both as an employee and a dependent. Benefits paid for Type I Dental Services will not be applied to the Policy Year Maximum.

### Date Started and Date Completed

We consider a *dental treatment* to be started as follows:

- for a full or partial denture, the date the first impression is taken;
- for a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared;
- for root canal therapy, on the date the pulp chamber is first opened;
- for periodontal surgery, the date the surgery is performed; and
- for all other *treatment*, the date *treatment* is rendered.

We consider a *dental treatment* to be completed as follows:

## DENTAL INSURANCE (continued)

- for a full or partial denture, the date a final completed appliance is first inserted in the mouth;
- for a fixed partial denture, crown, inlay and onlay, the date an appliance is cemented in place; and
- for root canal therapy, the date a canal is permanently filled.

### Pre-estimate

Whenever the expected cost of a *treatment* exceeds \$300, we recommend that a *dental treatment plan* be submitted to us for review before *treatment* begins. The *dental treatment plan* should be accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials as requested by us. We will notify you and your *dentist* of the benefits payable based upon the *dental treatment plan*. In estimating the amount of benefits payable, consideration will be given to the least costly alternative procedures and materials that may accomplish a result that meets broadly accepted standards of professional dental care as determined by us.

If a *dental treatment plan* is not completed within six months of the pre-estimate, we may consider it invalid. We may request the submission of a new *dental treatment plan*.

If you and your *dentist* decide on a more costly method of *treatment* than that pre-estimated by us, benefits payable for covered dental services for the more costly *treatment* will be limited to the benefits that would have been payable for covered dental services for the least costly alternative *treatment*. We will not pay the excess amount. Since this may result in significant out-of-pocket expense, we strongly encourage you to receive a pre-estimate for any *dental treatment plan* that is expected to exceed \$300 in cost.

### Alternative Benefits

In determining the benefits payable on a claim, we will consider other alternative procedures and materials that can be used to treat a dental problem or disease. The covered dental expense for a covered dental service provided will be limited to the *allowable charge* for the least costly covered dental service that accomplishes a result which meets broadly accepted standards of professional dental care as determined by us. You and your *dentist* may decide on a more costly procedure or material than we have determined to be satisfactory for the *treatment* of the dental problem or disease. In this event, we will not pay the excess amount. The benefit payable will be limited to the benefit that would have been payable had the least costly covered dental service been provided instead.

### Covered Dental Expenses

Covered dental expenses include only the lesser of the *dentists* actual charge or the *allowable charge* for expenses incurred by you or a *covered dependent*. The *treatment* must be:

- performed by or under the direction of a *dentist*, or performed by a *dental hygienist* or denturist;
- *dentally necessary*; and
- started and completed while you or your *covered dependent* are insured, except as otherwise provided in the Limited Extension of Benefits After Insurance Ends provision.

Expenses submitted to us must identify the *treatment* performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request X-rays, narratives and other diagnostic information, as we see fit, to determine benefits.

We will only pay benefits for covered dental expenses incurred for *treatment* that, in our opinion, has a reasonably favorable prognosis for the patient.

We consider a temporary *treatment* to be an integral part of the final *treatment*. The sum of the fees for temporary and final *treatment* will be used to determine whether the charges are an *allowable charge*.

The Listing of Covered Dental Services is a complete list of covered dental services. We will not pay benefits

## DENTAL INSURANCE (continued)

for expenses incurred for any service not listed below, unless we agree to accept an unlisted service as a covered dental service. We will not accept any unlisted service which is not similar to, or which does not accomplish a result similar to, a listed service. In any event, the choice of whether or not to accept an unlisted service is solely ours. If we do accept an unlisted service as a covered dental service, benefits will be payable on a basis consistent with benefits for similar covered dental services which would provide the least costly adequate *treatment* of your or your *covered dependents* dental condition according to broadly accepted standards of professional dental care as determined by us.

### Listing of Covered Dental Services

Maximum frequencies, maximum dollar amounts and other limits are shown here and under Special Limitations and General Exclusions for certain services. Services performed outside these limits are not covered dental services. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the Listing of Covered Dental Services. However, benefits will be payable based on the most current dental terminology.

#### Type I Dental Services

- Clinical Oral Evaluations
  - No more than 2 times per Calendar Year. Benefits are based on the *allowable charge* for periodic oral evaluation.
- Dental Prophylaxis
  - No more than 2 times per Calendar year. (Frequencies combined with periodontal maintenance.)
- Topical Fluoride Treatment
  - No more than 1 time in any 12 months in a row. Only for children under age 14 years.
- Sealants
  - No more than 1 time per tooth per person. Only for children under age 16 years. Only for permanent molar teeth.
- Space Maintenance (Passive Appliances)
  - Only for children under age 16 years. Service is deemed to include all adjustments made, or recementing done, within 6 months of installation.
- Treatment To Control Harmful Habits
  - Not covered if orthodontic related. Once per person. Only for children under age 16 years.
- Radiographs-Diagnostic Imaging
  - Complete Series (Including Bitewings) or Panoramic Film No more than 1 time in any 60 months in a row. A complete series is deemed to include bitewing x-rays and 10 or more periapical x-rays, or a panoramic film

## **DENTAL INSURANCE (continued)**

- One of either service no more than 1 time in any 60 months in a row. Benefits for a panoramic film may also be payable in connection with the removal of impacted teeth.
  - Bitewings No more than 1 time in any 12 months in a row.
  - Periapical No more than 4 x-rays in any 12 months in a row.
  - Occlusal Film No more than 2 films in any 12 months in a row.
  - Extraoral No more than 2 films in any 12 months in a row.
  - Sialography

### **Type II Dental Services**

- Minor Restorations (Fillings)
  - Amalgam and Composite Restorations
    - Replacement of existing minor restoration (filling) is deemed to be a covered dental service only if at least 24 months have passed since existing minor restoration (filling) was placed, unless required by new decay in an additional tooth surface.
    - The service is deemed to include local anesthesia.
    - Multiple restorations on one surface are deemed to be a single restoration.
    - Mesial-lingual, distal-lingual, mesial-facial, and distal-facial resin restorations on anterior teeth are deemed to be single surface restorations.
- Other Restorative Services
  - Pin Retention -- No more than 1 time per restoration. Deemed to be a covered dental service only in conjunction with amalgam or resin restoration.
- Oral Surgery
  - Minor Oral Surgery -- Each service is deemed to include local anesthesia and routine postoperative care.
    - Simple Extractions (Does not include Surgical Extractions)
    - Surgical Incision and Drainage of Abscess
    - Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
- Endodontics -- For applicable procedures, the service is deemed to include all pre-operative, operative, and post-operative x-rays, local anesthesia, and routine follow-up care.
  - Pulpotomy -- Only for Deciduous Teeth
  - Endodontic Therapy

## DENTAL INSURANCE (continued)

- Endodontic Retreatment -- Service is deemed a covered dental service if at least 24 months have passed since the initial treatment.
- Apexification-Recalcification Procedures
- Apicoectomy Surgery
- Periradicular Services
  - Retrograde Filling
  - Root Amputation
- Other Endodontic Procedures
  - Hemisection (Including any root removal), Not Including Endodontic Therapy -- covered dental services do not include fixed partial dentures replacing the extracted part of a hemisected tooth.
- Minor Periodontics
  - Adjunctive Periodontal Service
    - Provisional Splinting -- covered dental services do not include inlays, onlays, crowns, or other cast or prepared restorations made for the purpose of splinting.
    - Scaling and Root Planing -- no more than 1 time per area of the mouth in any 24 months in a row. The benefit for three or more quadrants of scaling and root planing, performed during the same appointment, will be limited to benefits equivalent to one quadrant of scaling and root planing. Benefits for prophylaxis and scaling and root planing, performed during the same appointment, will be based on the allowable charge for a prophylaxis. Benefits for scaling and root planing and periodontal maintenance, performed during the same appointment, will be based on the *allowable charge* for periodontal maintenance.
    - Occlusal Adjustment -- no more than 1 full mouth treatment in any 12 months in a row. Only when performed with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service).
- Other Periodontal Services
  - Periodontal Maintenance -- no more than 2 times per Calendar year. Service is deemed to include scaling and root planing, a recall evaluation, charting, polishing of teeth, and oral hygiene instruction. (Frequencies combined with prophylaxis.)
- Major Periodontics -- For applicable procedures, services are deemed to include local anesthesia, temporary restorations and appliances, and one-year follow-up care.
  - Surgical Services -- If more than one periodontal surgical service is performed per area of the mouth, only the most inclusive surgical service performed will be considered a covered dental expense. The following surgeries are covered only if more than 36 months have passed since gingivectomy, flap surgery, or osseous surgery was performed in that same area of the mouth.
    - Gingivectomy or Gingivoplasty
    - Gingival Flap Procedure
    - Osseous Surgery
  - Clinical Crown Lengthening
  - Guided Tissue Regeneration

## **DENTAL INSURANCE (continued)**

- Soft Tissue Graft
- Subepithelial Connective Tissue Graft
- Distal or Proximal Wedge
- Occlusal Guard No more than 1 in any 24 months in a row.
- Other Type II Services
  - Bacteriologic Studies For Determination of Pathologic Agents
  - Palliative (Emergency) Treatment of Dental Pain - Minor Procedure Deemed to be a separate covered dental service only if no other service is rendered during the visit, except x-rays.
  - Therapeutic Drug Injection
  - Accession and examination of tissue

### **Type III Dental Services**

- Complex Oral Surgery
  - Surgical Extractions
- Other Complex Oral Surgery Procedures
  - Oroantral Fistula Closure
  - Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth and/or Alveolus
  - Tooth Transplantation
  - Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption
  - Biopsy of Oral Tissue
  - Transseptal Fiberotomy
  - Alveoplasty
  - Vestibuloplasty
  - Removal of lateral exostosis maxilla or mandible
  - Removal of Foreign Body, Skin, or Subcutaneous Areolar Tissue
  - Removal of Reaction-Producing Foreign Bodies Musculoskeletal System
  - Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body
  - Frenulectomy (Frenectomy or Frenotomy) Separate Procedure
  - Excision of Hyperplastic Tissue - Per Arch
  - Excision of Pericoronal Gingiva
  - Sialolithotomy
  - Excision of Salivary Gland
  - Sialodochoplasty
  - Closure of Salivary Fistula

## DENTAL INSURANCE (continued)

- If more than one complex surgical procedure is performed per area of the mouth, only the most inclusive surgical procedure performed will be considered a covered dental expense.
- Adjunctive General Services -- Each service is deemed a separate covered dental service only when medically required for a complex oral surgery which is itself a covered dental service. Our decision is final for the purposes of determining covered dental services under the policy.
  - Anesthesia
  - Intravenous Sedation
- Major Restorations - Initial (New) or Replacement. For applicable procedures, the service is deemed to include local anesthesia, temporary restorations and appliances, and one-year follow-up care.
  - Inlay/Onlay Restorations
    - Benefits are based on the *allowable charge* of a metallic inlay or onlay.
  - Crowns
    - Benefits are based on the *allowable charge* for predominantly base metal.
    - For children under age 16 years, covered dental services for crowns on deciduous or primary teeth are limited to prefabricated stainless steel or prefabricated resin crowns.
  - Labial Veneers (Only for Anterior Teeth)
  - Other Restorative Services -- Only under unusual circumstances when required, as determined by us, for retention and preservation of the tooth. Service is deemed to include pins.
    - Core Build-up, Including Any Pins
    - Cast Post And Core
    - Prefabricated Post And Core
- Complete Dentures And Partial Dentures
  - Service is deemed to include all replacement teeth and all clasps and rests.
- Fixed Partial Denture Pontics
  - Fixed Partial Denture Retainers - Inlays/Onlays, And Crowns -- Benefits based on the *allowable charge* for predominantly base metal.
    - Two or more contiguous spans of fixed partial denture work, regardless of the number of pontics and abutments involved, are deemed to be a single fixed partial denture with benefits payable based on a single date completed. Benefits for such a fixed partial denture will not be applied to more than one *policy year*.
- Tissue Conditioning
  - No more than 1 time in any 36 months in a row.
  - Only if at least 12 months have passed since the insertion of a full or partial denture.
- Major Restorations --Maintenance -- For applicable procedures, the service is deemed to include local anesthesia, temporary restorations and appliances, and one year follow-up care. Covered only if more than 6 months have passed since the initial insertion.
  - Recement Inlays



## DENTAL INSURANCE (continued)

- Recement Crown
- Recement Fixed Partial Denture
- Crown Repair
- Repairs To Complete Dentures, Partial Dentures, Or Fixed Partial Dentures
  - Only if more than 6 months have passed since the initial insertion.
- Adjustment To Dentures
  - No more than 1 time in any 12 months in a row. Only if more than 6 months have passed since the initial insertion.
- Denture Rebase Procedures
  - No more than 1 time in any 36 months in a row. Only if more than 12 months have passed since the initial insertion.
- Denture Reline Procedures
  - No more than 1 time in any 36 months in a row. Only if more than 12 months have passed since the initial insertion.
- Other Type III Services
  - Diagnostic Casts -- No more than 1 time in any 36 months in a row. Only if required for extensive bilateral prosthetic dentistry other than dentures. Not a covered dental service if for orthodontic evaluation.

### Special Limitations

#### Major Restorations

Covered Dental Expenses and covered dental services do not include, and we will not pay benefits for, the following:

- Inlays, onlays, crowns, cast restorations, veneers or other laboratory prepared restorations:
  - on teeth which may be restored with a direct placement filling material;
  - in the absence of extensive decay or fracture;
  - for loss of tooth structure due to attrition or abrasion; or
  - for children under age 16 years, except for prefabricated stainless steel or prefabricated resin crowns on deciduous or primary teeth.
- The initial placement of a complete or partial denture unless:
  - it includes the replacement of a functioning natural tooth extracted while you or your covered dependent are insured under the policy; and
  - that tooth cannot be added to an existing partial denture. We will not pay benefits for the initial placement of a complete or partial denture which replaces only those natural teeth missing on the date your or your covered dependents' insurance begins.
- The initial placement of a fixed partial denture unless:
  - it includes the replacement of a *functioning natural tooth* extracted while insured under the *policy*;

## DENTAL INSURANCE (continued)

and

- that tooth was not an abutment to an existing fixed partial denture that is less than 7 years old (5 years old if a cast metal, resin bonded fixed retainer). Benefits for such initial placement are limited to benefits for the replacement of those *functioning natural teeth* which were extracted while you or your *covered dependent* are insured under the *policy* and were not abutments to an existing fixed partial denture less than 7 years old (5 years old if a cast metal, resin bonded fixed retainer). We will not pay benefits to replace *natural teeth* missing on the date that your or your *covered dependents* insurance begins.
- The replacement of inlays, onlays, crowns, core build-ups, cast restorations, or other laboratory prepared restorations unless:
  - at least 7 years have passed since the last placement (5 years for labial veneers, 3 years for prefabricated stainless steel or prefabricated resin crowns); and
  - they are not serviceable and cannot be restored to function.
- The replacement of a complete or partial denture, or the addition of teeth to a partial denture, unless:
  - replacement occurs at least 5 years after the initial date of insertion of the existing denture, provided the existing denture is not serviceable and cannot be restored to function; or
  - the addition of a tooth to a partial denture is required due to the *dentally necessary* extraction of a *functioning natural tooth* while you or your *covered dependent* are insured under the *policy*; or
  - the replacement is made *dentally necessary* by an *accidental non-chewing injury* to a *sound natural tooth*, provided the replacement is completed within 12 months of the injury.
- The replacement of a fixed partial denture unless:
  - replacement occurs at least 7 years (5 years for a cast metal, resin bonded fixed retainer) after the initial date of insertion of the existing fixed partial denture, provided the existing fixed partial denture is not serviceable and cannot be restored to function; or
  - replacement is required due to the *dentally necessary* extraction of a *functioning natural tooth* while you or your *covered dependent* are insured under the *policy*, provided that the extracted tooth was not serving as an abutment to the existing fixed partial denture; or
  - replacement is made, provided the replacement is made *dentally necessary* by an *accidental non-chewing injury* to a *sound natural tooth*, and is completed within 12 months of the injury.
- The replacement of an existing partial denture with fixed partial denture work unless upgrading to fixed partial denture work is essential, as determined by us, to the correction of your or your *covered dependents* dental condition.
- The replacement of teeth beyond the normal complement.
- Appliances, inlays, onlays, crowns, or other cast or laboratory prepared restorations used primarily for the purpose of splinting.
- Facings on crowns or fixed partial dentures on molar teeth (which are always considered cosmetic under the *policy*).
- Implants, insertion of implants or related appliances, or surgical removal of implants.

## DENTAL INSURANCE (continued)

### Coverage Under the Group's Medical Plan

If benefits for any covered dental expenses are provided under your employer's medical plan (if any), benefits otherwise payable for those expenses under the policy will be reduced by the amount of benefits payable for those expenses under your employer's medical plan.

### General Exclusions

Covered dental expenses and covered dental services do not include, and we will not pay benefits for, the following:

- *treatment* which:
  - is not included in the list of covered dental services; or
  - has a date started before your or a *covered dependent's* insurance begins; or
  - has a date started before any applicable waiting period has been served; or
  - has a date completed after your or a *covered dependents* insurance ends, except as may be specifically provided under Limited Extension of Benefits After Insurance Ends.
- any *treatment*, the sole or primary purpose of which relates to:
  - the change or maintenance of vertical dimension; or
  - the alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service); or
  - bite registration; or
  - bite analysis.
- any *treatment* required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint or its associated structures.
- athletic mouthguards; replacement of lost or stolen appliances; myofunctional therapy; infection control; oral hygiene instruction; separate charges for acid etch; *treatment* of jaw fractures; orthognathic surgery; personal supplies; broken appointments; completion of claim forms; exams required by a third party; travel time; transportation costs; professional advice given on the phone.
- *treatment* which:
  - is not *dentally necessary*; or
  - does not have uniform professional endorsement; or
  - is experimental or investigational in nature.
- *treatment* which does not have a reasonably favorable prognosis, as determined by us.
- *treatment* provided primarily for cosmetic purposes.
- *treatment* received as a result of disease, defect, or *injury* due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit an assault or felony.
- *treatment* of *injury* arising out of, or in the course of, doing any work for pay, profit, or gain, whether on your or a *covered dependent's* job or any other job.

## DENTAL INSURANCE (continued)

- *treatment* of an intentionally self-inflicted *injury*.
- *treatment* performed outside of the United States of America, other than *emergency dental treatment*. However, for such *emergency dental treatment*, the benefits payable shall not exceed the *allowable charge* for the *treatment* at your employer's principal address (shown in the application for insurance) in the USA.
- *treatment* rendered by a dental clinic or similar clinic that is operated by your or your spouse's employer, labor union, or similar group.
- *treatment* of a provider who is a member of your or your spouse's immediate family.
- *treatment* for which a charge would not have been made in the absence of insurance.
- *treatment* for which you or your *covered dependent* do not have to pay, except when payment of such benefits is required by law and only to the extent required by law.
- *treatment* that has not been both delivered to and accepted by you or your *covered dependent*.
- *orthodontic treatment*, unless such insurance is provided under the list of covered dental services.

### Limited Extension of Benefits After Insurance Ends

If an otherwise non-orthodontic covered dental service is started while you or your *covered dependent* are insured under the *policy* (and after any applicable waiting periods are served), but is completed after the day your or your *covered dependents* insurance ends, we will pay benefits for otherwise covered dental expenses incurred for that service subject to all of the following rules:

- Benefits are not available to you or your *covered dependent* if, on the day after insurance ends, you or your *covered dependent*, obtain, or are eligible to obtain, dental care coverage under any group or governmental plan;
- Benefits are not available to you or your *covered dependent* if insurance ends because any required premium contributions were stopped while still eligible for insurance;
- Benefits are not available for any *treatment* started after the day your or your *covered dependents* insurance ends;
- Benefits are payable only in the amount that would have been payable, and subject to the same provisions that would have applied, had your or your covered dependent's insurance still been in effect;
- Benefits are payable only if the *treatment* is completed within 31 days after the date your or your *covered dependents* insurance ends, unless you or your *covered dependent* become injured or sick after the *treatment* is started and that is the only reason the *treatment* could not be completed during those 31 days. Then, benefits are payable only if the *treatment* is completed before the earlier of:
  - the date 31 days after the first date the *injury* or sickness no longer prevents the *treatment* from being completed; or
  - the date 91 days after the date your or your *covered dependents* insurance ends;
- We will not pay any benefits for treatment which is completed on or after the first date you or your *covered dependent* obtain, or are eligible to obtain dental care coverage under any group or governmental plan.

## COORDINATION OF BENEFITS

### Applicability

The Coordination of Benefits (COB) provision applies when you or a *covered dependent* has dental care coverage under more than one *plan*. *Plan* is defined below. All of the benefits provided under the *policy* are subject to *this provision*.

### Definitions

*Allowable expense* means a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any *plan* covering the person. When a *plan* provides benefits in the form of services, the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense that is not covered by any *plan* covering the person is not an *allowable expense*. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging you or a *covered dependent* is not an *allowable expense*.

The following are examples of expenses that are not *allowable expenses*:

- If you or a *covered dependent* is covered by 2 or more *plans* that compute their benefit payments on the basis of:
  - dentally necessary, usual and customary fees; or
  - relative-value, schedule-reimbursement methodology; or
  - other similar reimbursement methodology,

any amount in excess of the highest reimbursement amount for a specific benefit is not an *allowable expenses*.

- If you or a *covered dependent* is covered by 2 or more *plans* that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *allowable expenses*.
- If you or a *covered dependent* is covered by one *plan* that calculates its benefits or services on the basis of:
  - dentally necessary, usual and customary fees; or
  - relative-value, schedule-reimbursement methodology; or
  - other similar reimbursement methodology; and
  - another plan that provides its benefits or services on the basis of negotiated fees;

the *primary plan's* payment arrangement will be the *allowable expenses* for all *plans*.

However, if the provider has contracted with the *secondary plan* to provide:

- the benefit or service for a specific negotiated fee; or
- payment amount that is different than the *primary plan's* payment arrangement; and
- if the provider's contract permits,

the negotiated fee or payment shall be the *allowable expenses* used by the *secondary plan* to determine its benefits.

- The amount of any benefit reduction by the *primary plan* because you or a *covered dependent* has failed to comply with the *plan* provisions is not an *allowable expense*. Examples of these types of *plan* provisions include:

## COORDINATION OF BENEFITS (continued)

- any required second opinion,
- some form of predetermination of *treatment*, and
- preferred provider arrangements.

*Birthday* refers only to month and day in a calendar year and does not include the year of birth.

*Claim* means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

- services (including supplies); or
- payment for all or a portion of the expenses incurred; or
- combination of services or expenses shown above; or
- indemnification.

*Claim period* means a calendar year. A *claim period* will not start before a person's effective date of insurance under *this plan* nor extend beyond the last day the person is covered under *this plan*.

*Closed-panel plan* is a *plan* that provides dental care benefits to you or a *covered dependent* primarily in the form of services through a panel of providers that

- have contracted with or are employed by the *plan*, and
- excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

*Consolidated Omnibus Budget Reconciliation Act of 1985* or "COBRA" means coverage provided under a right of continuation compliant with federal law.

*Custodial parent* is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

*Medicaid* means Title XIX of the Social Security Act of 1965 as amended.

*Plan* means any of the following that provides benefits or services for dental care or *treatment*:

- Group and non-group insurance contracts, dental service prepayment coverage, or subscriber plans;
- Dental Maintenance Organization (DMO) contracts or Health Maintenance Organization (HMO) contracts;
- Closed-panel plans or other forms of group or group-type coverage, as permitted by law or regulation (whether insured or uninsured);
- Dental benefits under group or individual automobile contracts, as permitted by state law or regulation; and
- Medicare or any other federal governmental plan, as permitted by law.

If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same *plan* and there is no COB among those separate contracts.

*Plan* does not include any of the following:

## COORDINATION OF BENEFITS (continued)

- Hospital indemnity coverage or other fixed indemnity coverage;
- Accident-only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage, as defined by state law;
- School accident-type coverage;
- Benefits for non-dental services provided under long-term care coverage;
- Medicare supplement coverage;
- A state plan under Medicaid; or
- Coverage under a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

Each contract for coverage shown above is a separate *plan*. If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

*Primary plan* means the *plan* that pays or provides its benefits first, according to its terms of coverage and without regard to benefits under any other *plan*.

Except as provided below, a *plan* that does not contain a COB provision that is consistent with *this provision* is always the *primary plan* unless the provisions of both *plans* state that the *plan* with a COB provision is the *primary plan*.

Coverage that is obtained by virtue of membership in a group that is:

- designed to supplement a part of a basic package of benefits, and
- provides that this supplementary coverage,

shall be excess to any other parts of the *plan* provided by the *policyholder*.

An example of this type of situation is insurance-type coverage that is written in connection with a *closed-panel plan* to provide out-of-network benefits.

*Secondary plan* means the *plan* that determines its benefits after those of another *plan* and may reduce the benefits it pays so that all *plan* benefits do not exceed 100% of the total *allowable expenses* incurred by you or a covered dependent during the *claim period*.

*This plan* means the benefits provided by the *policy*. When there are more than two *plans*, *this plan* may be a *primary plan* to one or more other *plans*, and may be a *secondary plan* to a different *plan(s)*.

This provision means the provision for coordination between the benefits of *this plan* and other *plans*.

Other definitions that may apply to *this provision* appear in the Definitions provisions of this *policy*.

## COORDINATION OF BENEFITS (continued)

### Order of Benefit Determination

When you or a *covered dependent* has dental care coverage under more than one *plan*, each *plan* determines its order of benefits using the first of the following rules that apply:

#### 1. Non-Dependent or Dependent

The *plan* that covers the person other than as a dependent, e.g., as an employee, member, policyholder, subscriber or retiree is the *primary plan* and the *plan* that covers the person as a dependent is the *secondary plan*.

However, if

- you or a *covered dependent* is a Medicare beneficiary and,
- as a result of federal law,
  - Medicare is secondary to the *plan* covering the person as a dependent; and
  - primary to the *plan* covering the person as other than a dependent (e.g., a retired employee);

then, the order of benefits between the two *plans* is reversed so that

- the *plan* covering the person as an employee, member, policyholder, subscriber or retiree is the *secondary plan*, and
- the other *plan* is the *primary plan*.

#### 2. Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, when a dependent child is covered by more than one *plan* the order of benefits is determined as follows:

- For a *covered dependent* child whose parents are married or are living together, whether or not they have ever been married:
  - The *primary plan* is the *plan* of the parent whose *birthday* falls earlier in the calendar year; or
  - If both parents have the same *birthday*, the *primary plan* is the *plan* that has covered the parent the longest.
- For a *covered dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
  - If a court decree states that one of the parents is responsible for the dependent child's dental care expenses or dental care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is the *primary plan*. This rule applies to *plan* years commencing after the *plan* is given notice of the court decree;
  - If a court decree states that both parents are responsible for the *covered dependent* child's dental care expenses or dental care coverage, benefits will be determined according to the *birthday* rule described above;
  - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the *covered dependent* child, benefits will be determined according to the *birthday* rule described above; or
  - If there is no court decree allocating responsibility for the dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:
    - The plan covering the custodial parent;



## COORDINATION OF BENEFITS (continued)

- The plan covering the spouse of the custodial parent;
- The plan covering the non-custodial parent; and then
- The plan covering the spouse of the non-custodial parent.
  - For a *covered dependent* child covered under more than one *plan* of individuals who are the parents of the child, benefits will be determined according to the *birthday* and longer or shorter rules, as if those individuals were the parents of the child.

### 3. Active Employee or Retired or Laid-off Employee

- The *primary plan* is the *plan* that covers a person as an active employee, e.g., an employee who is neither laid off nor retired.
- The *secondary plan* is the *plan* covering that same person as a retired or laid-off employee.

The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee.

If the other *plan* does not have this rule, and therefore, the *plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rules described in item 1 above can determine the order of benefits.

### 4. COBRA or State Continuation Coverage

If you or your *covered dependent* has coverage provided under

- COBRA, or
- continuation provided by state or other federal continuation law, and

is covered under another *plan*, then

- the *primary plan* is the *plan* covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree, and
- the *secondary plan* is the plan providing coverage under COBRA, state or other federal continuation law.

If the other *plan* does not have this rule, and therefore, the *plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the *birthday* rule can determine the order of benefits.

### 5. Longer or Shorter Length of Coverage

- The *primary plan* is the *plan* that covered the person as an employee, member, policyholder, subscriber or retiree longer.
- The *secondary plan* is the *plan* that covered the person the shorter length of time.

If none of the rules described above determine the order of benefits, the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan*. In addition, *this plan* will not pay more than it would have paid had it been the *primary plan*.

## Effect on Benefits

When *this plan* is the *secondary plan*, it may reduce its benefits so that the total benefits paid or provided by all *plans* during a *claim period* are not more than the total *allowable expenses*.

In determining the amount to be paid for any *claim*, the *secondary plan* will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any *allowable expense* under its *plan* that is unpaid by the *primary plan*. The *secondary plan* may then reduce its payment by the amount so that, when combined with the amount paid by the *primary plan*, the total benefits paid or provided by all *plans* for the *claim* do not exceed the total *allowable expense* for that *claim*.

In addition, the *secondary plan* shall credit to its *plan* deductible any amounts it would have credited to its

## COORDINATION OF BENEFITS (continued)

deductible in the absence of other dental care coverage.

If you or a *covered dependent* is enrolled in two or more *closed-panel plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and other *closed-panel plans*.

If you or a *covered dependent* is covered by more than one dental benefit *plan*, you should file all your claims with each *plan*.

### Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply the rules of *this provision* and to determine benefits payable under *this plan* and other *plans*. We may get the facts we need from or give them to other organizations or persons for the purpose of:

- applying the rules of *this provision*; and
- determining benefits payable under this *plan* and other *plans* covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under *this plan* must give us any facts we need to apply those rules and determine benefits payable.

### Facility of Payment

A payment made under another *plan* may include an amount that should have been paid under *this plan*. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under *this plan*. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

### Right Of Recovery

If we pay more than we should have paid under *this provision*, we may recover the excess from one or more of the persons it has paid or for whom it has paid. Or, we may recover the excess from any other person or organization that may be responsible for the benefits or services provided for you or a *covered dependent*. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

## CLAIM PROVISIONS

### Payment of Benefits

We will pay benefits when we receive all the required proof of covered loss.

### To Whom Payable

We will pay dental benefits directly to the providers of dental services for treatment of you or your covered dependents, if you have assigned your benefits to the providers. We will pay dental benefits to you, if you have not assigned your benefits to the providers. After your death, we have the option to pay any benefits due to your spouse, to the providers of the treatment, or to your estate.

### Authority

We have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the Policy. All determinations and interpretations made by us are conclusive and binding on all parties.

### Filing a Claim

1. Your *dentist* should send us notice of claim for dental *treatment*. We must have written notice of any insured loss within 30 days after it occurs, or as soon as reasonably possible. You can send the notice to our *home office*, one of our regional claims offices, or to one of our agents. We need enough information to identify you as a *covered person*. If charges for dental *treatment* are expected to be \$300 or more, you can receive an estimate of benefits payable before *treatment* begins by following the procedures outlined in the Pre-estimate provision.
2. Within 15 days after the date of the notice, we will send you certain claim forms. The forms must be completed and sent to our *home office* or one of our regional claims offices. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.
3. The time limit for filing a claim is 90 days after the date of the loss.
4. To decide our liability, we may require:
  - itemized bills,
  - proof of benefits from other sources, and
  - proof that you have applied for all benefits from other sources, and that you have furnished any proof required to get them.

For dental expenses, we may require additional information to determine our liability, including, but not limited to:

- a complete dental charting indicating extractions, missing teeth, fillings, prosthesis, periodontal pocket depths, orthodontic relationship and the dates work was previously performed, and
- preoperative x-rays, study models, laboratory and/or hospital reports.

We will ask you to authorize the sources of medical and dental services to release your medical information. If you do not furnish any required information or authorize its release, we will not pay benefits.

If it is not reasonably possible to give proof on time, we will not deny or reduce your claim if you give us proof as soon as reasonably possible.

### Physical Exam

We may ask you to be examined as often as we require at any time we choose. We will pay for any exam we require.

## **CLAIMS PROVISIONS (continued)**

### **Limit on Legal Action**

No action at law or in equity may be brought against the policy until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations in your state has expired, but, in any case, not after 6 years from the date of loss.

### **Incontestability**

The validity of the policy cannot be contested after it has been in force for 2 years, except if premiums are not paid.

Any statement made by the policyholder or a covered person will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the covered person or the beneficiary.

No statement, except fraudulent misstatement, made by a covered person about insurability will be used to deny a claim for a loss incurred or disability starting after coverage has been in effect for 2 years.

No claim for loss starting 2 or more years after the covered persons effective date may be reduced or denied because a disease or physical condition existed before the persons effective date, unless the condition was specifically excluded by a provision in effect on the date of loss

### **Overpayment**

If a benefit is paid under the policy and it is later shown that a lesser amount should have been paid, we will be entitled to a refund of the excess amount from the provider or you.

### **Subrogation Rights**

In the event of any payments for benefits provided to you or a covered dependent under the policy, we, to the extent of our payments, will be subrogated to all rights of recovery you or your dependent have against any person or organization. You or your dependent will execute and deliver any instruments and papers as may be required and do whatever else is necessary to secure those rights to us and will do nothing after loss to prejudice our rights. If we are precluded from exercising our Subrogation Rights, we may exercise our Right to Reimbursement.

### **Right to Reimbursement**

If you or a covered dependent: (a) seek legal recourse (whether by suit, settlement, judgment or otherwise) against any person or organization; and (b) recover payment, in whole or in part, from any such person or organization for the benefits previously paid under the policy, then you or your dependent must reimburse us for all payments made under the policy for which you have received reimbursement.

Any payments made prior to determination of work-related injury, will be reimbursed upon determination of such payment.

However, the reimbursement will not exceed: (a) the amount of the benefit payments made under the policy for which payment is recovered from any person or organization; or (b) the amount recovered from any such person or organization as payment for the same covered dental expenses.

You or your covered dependents are not obligated by this provision to seek legal action against any person or organization for which benefits have been paid under the policy.

## **GENERAL PROVISIONS**

### **Entire Contract**

The policy and the policyholders application attached to it are the entire contract. Any statement made by you or the policyholder is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

### **Errors**

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary, but not beyond 3 years before the date the error was found. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

### **Misstatements**

If any information about a person is misstated, the facts will determine whether insurance is in effect and in what amount. We will equitably adjust the premium.

### **Individual Certificates**

We will send certificates to the policyholder to give to each covered person. The certificate will state the insurance to which the person is entitled. It does not change the provisions of the policy.

### **Workers Compensation**

The policy is not in place of, and does not affect any states requirements for coverage by Workers Compensation insurance.

### **Agency**

Neither the policyholder, any employer, any associated company, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

## **ENDORSEMENT**

Effective on and after its effective date, the Certificate is endorsed as follows:

At the request of the policyholder, for dependent dental insurance, the term spouse shall also mean a domestic partner. A domestic partner is defined in the policyholders Declaration of Domestic Partnership agreement.

## HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice applies to our HIPAA covered healthcare plans, including dental, vision, cancer only, hospital indemnity, and critical illness.

### **I. Our Commitment**

Union Security Insurance Company, and the prepaid dental companies\* are committed to protecting the personal information entrusted to us by our customers. The trust you place in us when you share your personal information is a responsibility we take very seriously and is the cornerstone of how we conduct our business

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

### **II. Our Use and Disclosure of Your PHI**

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

Other examples of possible disclosures for purposes of healthcare operations include:

- Underwriting our risk and determining rates and premiums for your healthcare plan;
- Determining your eligibility for benefits;
- Reviewing the competence and qualifications of healthcare providers;
- Conducting or arranging for review, legal services, and auditing functions, including fraud and abuse detection and compliance;
- Business planning and development;
- Business management and general administrative duties such as cost-management, customer service, and resolution of internal grievances;
- Other administrative purposes.

We can also make disclosures under the following circumstances without your permission:

- As required by law, including response to court and administrative orders, or to report information about suspected criminal activity;
- To report abuse, neglect, or domestic violence;
- To authorities that monitor our compliance with these privacy requirements;

- To coroners, medical examiners, and funeral directors;
- For research and public health activities, such as disease and vital statistic reporting;
- To avert a serious threat to health or safety;
- To the military, certain federal officials for national security activities, and to correctional institutions;
- To the entity sponsoring your group healthcare plan but only for purposes of enrollment, disenrollment, and eligibility, or for the purpose of giving the plan sponsor summary information when necessary to help make decisions regarding changes to the plan. If the plan sponsor has certified that its plan documents have been amended to include certain privacy provisions, we may also disclose protected health information to the plan sponsor to carry out plan administration functions that the plan sponsor performs on behalf of the plan;
- To a spouse, family member, or other personal representative if they can show they are assisting in your care or payment of your care and then, without an authorization, only basic information about the status or payment of a claim.

Unless you give us written authorization, we cannot use or disclose your PHI for any reason except as otherwise described in this notice. including uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute the sale of protected health information. We are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes. You may revoke your written authorization at any time by writing us at the address indicated at the end of this notice.

### III. Your Individual Rights

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

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



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

#### **IV. Who to Contact for Questions and Complaints**

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

Mailing Address:	Sun Life Financial Privacy Officer P.O. Box 419052 Kansas City, MO 64141-6052
Telephone:	(800) 733-7879
Email:	SLF_US_Privacy@sunlife.com
Web Site:	<a href="http://www.sunlife.com/us">www.sunlife.com/us</a>

#### **V. Organizations Covered by This Notice**

This notice applies to the privacy practices of the organizations referenced below. These organizations may share your PHI with each other as needed for payment activities or health care operations relating to the healthcare plans that we provide.

#### **VI. Effective Date of This Notice: April 14, 2003**

Revised: October 21, 2016

\* In this notice, "we", "us", and "our" refer to Union Security Insurance Company and the following prepaid dental companies: DentiCare of Alabama, Inc., Union Security DentalCare of Georgia, 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., Union Security DentalCare of New Jersey, Inc.

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*Union Security Insurance Company*  
2323 Grand Boulevard  
Kansas City, Missouri 64108-2670

G933

January 1, 2020

# **Group Dental Appeals Process Information Packet**

## **Group Dental Appeals Process Information Packet Union Security Insurance Company**

**CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS THAT WE MAKE ABOUT YOUR DENTAL CARE.**

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

We will send you a copy of this information packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we will also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call our dental claims toll-free number 800.442.7742 to ask for a copy.

At the back of this packet, you will find a form that you can use for your appeal. The Arizona Department of Insurance and Financial Institutions ("Department") developed these forms to help people who want to file a dental care appeal. You are not required to use them. We 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 800.325.2548 or call us at our toll-free number 800.442.7742.

### **How to Know When You Can Appeal**

When we deny all or a portion of a dental claim, we will notify you of your right to appeal that decision. Your notice may come directly from us or through your treating provider.

### **Decisions You Can Appeal**

You can appeal the following decisions:

1. We do not pay for a service that you have already received.
2. We deny all or a portion of a dental claim because we determined that an alternate treatment would accomplish a professionally satisfactory result.
3. We deny all or a portion of a dental claim because we determine that it is not covered under your insurance policy, and you believe it is covered.

### **Decisions You Cannot Appeal**

You cannot appeal the following decisions:

1. You disagree with our decisions as to the amount of "usual and customary charges."
2. You disagree with how we are coordinating benefits when you have dental insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your dental plan deductible.
4. You disagree with the amount of coinsurance or copayments that you have paid.
5. You disagree with our decision to issue or not issue a dental policy to you.
6. You are dissatisfied with any rate increase you may receive under your dental insurance policy.
7. You believe that we have 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 and Financial Institutions, Consumer Affairs Division, 100 N. 15<sup>th</sup> Avenue, Suite 261, Phoenix, AZ 85007-2630.

## **Who Can File an Appeal?**

Either you or your treating dental 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 us a letter with the same information.

## **Description of the Dental Appeals Process**

The dental appeals process has two levels of appeals.

- Level 1 Formal Appeal
- Level 2 External Independent Dental Review

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

### **APPEALS PROCESS FOR DENIED DENTAL CLAIMS**

#### **Level 1: Formal appeal**

**Your request:** You may request Formal Appeal if: (1) you have dental coverage with us, and (2) we deny all or a portion of a dental claim. You have 2 years from our first denial notice to request Formal Appeal. To help us make a decision on your appeal, you or your provider should also send us information (that you have not already sent us) to show why we should pay the claim. Send your appeal request and information to:

Union Security Insurance Company  
PO Box 2940  
Clinton, IA 52733-2940  
800.442.7742

**Our acknowledgement:** We have 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating dental provider a notice that we got your request.

**Our decision:** We have up to 60 days to decide whether we should change our decision and pay your claim. We will send you and your treating dental provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

**If we deny all or a portion of your dental claim:** You have 4 months to appeal to Level 2.

**If we grant your request:** We will pay the claim and the appeal is over.

**If we refer your case to Level 2:** We may decide to skip Level 1 and send your case straight to an independent reviewer at Level 2.

#### **Level 2: External, Independent Review**

**Your request:** You may appeal to Level 2 only after you have appealed through Level 1. You have 4 months after you receive our Level 1 decision to send us your written request for External Independent Review. Send your request and any more supporting information to:

Union Security Insurance Company  
PO Box 2940  
Clinton, IA 52733-2940  
800.442.7742

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

**The process:** If we deny all or part of your claim for dental services, the denial will be due to contract coverage. This means that the denial is made because we determine that a service is not covered under your insurance policy or because an alternate treatment would accomplish a professionally satisfactory result. For denials based on contract coverage, the Arizona Insurance Department is the independent reviewer.

### Contract Coverage Cases

Within 5 days after receiving your request, we will:

1. Mail a written acknowledgement of your request to the Insurance Director, you and your treating dental 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 our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reason of our decision.

Within 15 days of receiving this information, the Insurance Director must determine if the dental claim is payable, issue a decision, and send a notice to us, you, and your treating dental provider.

**Referral to the Independent Review Organization (“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 you, your treating dental provider, and us. If the IRO has decided that the claim is payable, we will issue payment. If the IRO agrees with our decision to uphold the denial, the appeal is over.

**The decision (contract coverage):** If you disagree with the Insurance Director’s final decision on a coverage issue, you may request a hearing with OAH. If we disagree with the Director’s determination of coverage issues, we 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. §20-2293) 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 dental provider who has your records will provide you or the person you specified with a copy of your dental records.

**Confidentiality:** Dental records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeals process, the relevant portions of your dental records may be disclosed only to people authorized to participate in the review process for the dental claim 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 us 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 us as soon as you get it. You must also give us the address and telephone number where you can be contacted. If the appeal is already at Level 2, 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 decision, you must pursue the dental appeals process before the Insurance Director can investigate a complaint you may have against our company 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 decision of insurers.
5. Review decision 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 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 5<sup>th</sup> business day after being mailed. “Properly addressed” means your last known address.

**Union Security Insurance Company**

PO Box 2940

Clinton Iowa 52733-2940

T 800.442.7742

**DENTAL CARE APPEAL REQUEST**

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

Insured member's name \_\_\_\_\_ Member policy no. \_\_\_\_\_

Name of representative pursuing appeal, if different from above \_\_\_\_\_

Mailing Address \_\_\_\_\_ Phone no. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Type of Denial: Denied Claim \_\_\_\_\_ Denied Service Not Yet Received \_\_\_\_\_

Name of Insurer that denied the claim \_\_\_\_\_

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 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 Arizona Department of Insurance and Financial Institutions Consumer Assistance number 602.364.2499 or 800.325.2548, or call us at our toll-free number 800.442.7742.

**Make sure to attach everything that shows why you believe your insurer should cover your claim, including:**

☐ Dental Records    ☐ Supporting Documentation (letter from your dentist, brochures, notes, receipts, etc.)

\_\_\_\_\_  
SIGNATURE OF INSURED OR AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
DATE

# ASRS - Fall 2018 PPO/Indemnity member satisfaction survey

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Start of Block: Default Question Block

Q2

Thank you for providing feedback for the Sun Life PPO Dental plan\*, a benefit offered through the Arizona State Retirement System (ASRS). Your feedback is important to us and will help us improve your plan and experience in the future. This survey will take approximately 3-5 minutes. Please carefully respond to each question presented. Then, simply follow the arrow prompts to complete and submit the survey. Your feedback is important to us. Thank you!

\*PPO plans are either the Freedom Basic plan or the Freedom Advance plan.

Thinking about your current dental plan...

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Q3 Have you used your dental plan in the past year?

☐ Yes (1)

☐ No (2)

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*Display This Question:*

*If Have you used your dental plan in the past year? = No*

Q9

Darn! At this time, we are looking to learn about experiences with our Dental plan from within the past year. Thank you though for your response and your time. We look forward to hearing from you in a future survey!

Remember, regular, preventative dental care can be beneficial to your mouth and body—be sure to make an appointment with your dental provider and visit with them soon. Please visit the



dedicated ASRS dental page ([www.sunlife.com/ASRS](http://www.sunlife.com/ASRS)) to find a dentist in your area and for more information about your plan.

*Skip To: End of Survey If Darn! At this time, we are looking to learn about experiences with our Dental plan from within th...() Is Displayed*

Q4 How satisfied are you with...

	Very satisfied (1)	Somewhat satisfied (2)	Neutral (3)	Somewhat dissatisfied (4)	Very dissatisfied (5)	Not applicable (6)
Sun Life's administration of your plan (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sun Life's online or mobile resources (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*Display This Question:*

*If How satisfied are you with... = Sun Life's administration of your plan [ Somewhat dissatisfied ]*

*Or How satisfied are you with... = Sun Life's administration of your plan [ Very dissatisfied ]*

Q5 Why haven't you been satisfied with Sun Life's administration of your plan?

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Q6 Have you called Sun Life and spoken with a customer service representative for any reason in the past 90 days?

☐ Yes (1)

☐ No (2)

*Skip To: Q9 If Have you called Sun Life and spoken with a customer service representative for any reason in the... = No*

Q7 When you called Sun Life, how satisfied were you with...

	Very satisfied (1)	Somewhat satisfied (2)	Neutral (3)	Somewhat dissatisfied (4)	Very dissatisfied (5)	Not applicable (6)
The ability to easily reach a representative (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The courteousness of the person you spoke with (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How knowledgeable the representative was (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The accuracy of the information given to you (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The ability to get your request/inquiry handled in one call (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page Break



Q8

Thank you for participating in the survey and sharing your feedback with us!

Don't forget...regular, preventative dental care can be beneficial to your mouth and body—be sure to make an appointment with your dental provider and visit with them soon. Please visit the dedicated ASRS dental page ([www.sunlife.com/ASRS](http://www.sunlife.com/ASRS)) to find a dentist in your area and for more information about your plan.

Please click on the arrow button below to submit your responses and complete the survey.

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*Display This Question:*

*If Have you called Sun Life and spoken with a customer service representative for any reason in the... = No*

Q9

At this time, we are looking to learn about experiences with our service team--those in particular from within the past 90 days. Thank you for your response, and your time. We look forward to hearing from you in a future survey!

Remember, regular, preventative dental care can be beneficial to your mouth and body—be sure to make an appointment with your dental provider and visit with them soon. Please visit the dedicated ASRS dental page ([www.sunlife.com/ASRS](http://www.sunlife.com/ASRS)) to find a dentist in your area and for more information about your plan.

Please click on the arrow button below to submit your responses and complete the survey.

*Skip To: End of Survey If At this time, we are looking to learn about experiences with our service team--those in particula...() Is Displayed*

**End of Block: Default Question Block**

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# ASRS - Fall 2018 Prepaid/DHMO member satisfaction survey

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Start of Block: Default Question Block

Q2 Thank you for providing feedback for the Sun Life Prepaid/DHMO Dental plan\*, a benefit offered through the Arizona State Retirement System (ASRS). Your feedback is important to us and will help us improve your plan and experience in the future. This survey will take approximately 3-5 minutes. Please carefully respond to each question presented. Then, simply follow the arrow prompts to complete and submit the survey. Your feedback is important to us. Thank you!

\*Prepaid/DHMO plans are either the Heritage Secure with SBA plan or the DHMO Dental Plan 220 with Orthodontia.

Thinking about your current dental plan...

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Q3 Have you used your dental plan in the past year?

☐ Yes (1)

☐ No (2)

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*Display This Question:*

*If Have you used your dental plan in the past year? = No*

Q9 At this time, we are looking to learn about experiences with our Dental plan from within the past year. Thank you for your response and your time. We look forward to hearing from you in a future survey!

Remember, regular, preventative dental care can be beneficial to your mouth and body—be sure to make an appointment with your dental provider and visit with them soon. Please visit the

dedicated ASRS dental page ([www.sunlife.com/ASRS](http://www.sunlife.com/ASRS)) to find a dentist in your area and for more information about your plan.

*Skip To: End of Survey If At this time, we are looking to learn about experiences with our Dental plan from within the past...() Is Displayed*

Q4 How satisfied are you with...

	Very satisfied (1)	Somewhat satisfied (2)	Neutral (3)	Somewhat dissatisfied (4)	Very dissatisfied (5)	Not applicable (6)
Sun Life's administration of your plan (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sun Life's online or mobile resources (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The quality of care from your network dentist (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The convenience of your dental appointments (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*Display This Question:*

*If How satisfied are you with... = Sun Life's administration of your plan [ Somewhat dissatisfied ]  
Or How satisfied are you with... = Sun Life's administration of your plan [ Very dissatisfied ]*

Q5 Why haven't you been satisfied with Sun Life's administration of your plan?

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Page Break

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Q6 Have you called Sun Life and spoken with a customer service representative for any reason in the past 90 days?

☐ Yes (1)

☐ No (2)

*Skip To: Q9 If Have you called Sun Life and spoken with a customer service representative for any reason in the... = No*

Page Break

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Q7 When you called Sun Life, how satisfied were you with...

	Very satisfied (1)	Somewhat satisfied (2)	Neutral (3)	Somewhat dissatisfied (4)	Very dissatisfied (5)	Not applicable (6)
The ability to easily reach a representative (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The courteousness of the person you spoke with (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How knowledgeable the representative was (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The accuracy of the information given to you (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The ability to get your request/inquiry handled in one call (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Page Break

Q8 Thank you for participating in the survey and sharing your feedback with us!

Don't forget...regular, preventative dental care can be beneficial to your mouth and body—be sure to make an appointment with your dental provider and visit with them soon. Please visit the dedicated ASRS dental page ([www.sunlife.com/ASRS](http://www.sunlife.com/ASRS)) to find a dentist in your area and for more information about your plan.

Please click on the arrow button below to submit your responses and complete the survey.

---

*Display This Question:*

*If Have you called Sun Life and spoken with a customer service representative for any reason in the... = No*

Q9

Darn! At this time, we are looking to learn about experiences with our service team--those in particular from within the past 90 days. Thank you though for your earlier feedback, and your time. We look forward to hearing more from you in a future survey!

Remember, regular, preventative dental care can be beneficial to your mouth and body—be sure to make an appointment with your dental provider and visit with them soon. Please visit the dedicated ASRS dental page ([www.sunlife.com/ASRS](http://www.sunlife.com/ASRS)) to find a dentist in your area and for more information about your plan.

Please click on the arrow button below to submit your responses and complete the survey.

End of Block: Default Question Block

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# NAPG Employer Survey

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## Start of Block: Default Question Block

Q\_intro The following questions will ask you to rate your experience with Sun Life in several areas such as account management and claims. Please rate your experience with Sun Life on a scale of 1-5 where 1= very poor experience and 5=excellent experience. An N/A option has also been provided in the event you did not experience certain parts of the process.



**Q2 How was your experience with your account manager in the following areas?**

	5=Excellent (5)	4=Very good (4)	3=Satisfactory (3)	2=Poor (2)	1=Very poor (1)	N/A (3)
How well your account manager responded to all inquiries within one business day (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your account manager used their expertise for day-to-day Client support using our reporting and analytics package (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your account manager resolved issues in a timely manner suggesting solutions and documenting outcomes (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page Break

**Q8 Would you like your Sun Life dedicated account contact to follow up with you on any of the responses you provided in this survey?**

☐ Yes (1)

☐ No (2)

End of Block: Default Question Block

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# National Account Performance Guarantee Scorecard

Sun Life is pleased to offer [the Arizona State Retirement system](#) comprehensive performance guarantees. Please find below the recent results for the period of [01/01/20--](#) through [12/31/20--](#).<sup>1</sup>

## Account Management

Our commitment	Measure	Q1	Q2	Q3	Q4	Annual Result
Account Managers will respond to all inquiries within 1 business day.	Annual satisfaction survey results of “Satisfied” or better	5	N/A	N/A	N/A	N/A
Account Managers will use their expertise for day-to-day Client support, using our reporting and analytics package.	Annual satisfaction survey results of “Satisfied” or better	5	N/A	N/A	N/A	N/A
Account Managers will resolve issues in a timely manner, suggesting solutions and documenting outcomes.	Annual satisfaction survey results of “Satisfied” or better	5	N/A	N/A	N/A	N/A

**At Sun Life, we put the Client at the center of everything we do, so we can be your best partner for benefits.**

1. Results will be based on the first 12 months post effective date. Performance results will be provided on quarterly basis. Annually, an average of the four quarters will be provided and then SLF will determine if a payment is warranted based on the agreement. Any annual payout will be based on received premium and fees by Sun Life. State mandated family leave administration is not part of this agreement.
2. Contingent on Sun Life receiving all pertinent information from Client, including final Client Plan & Services Grid, signed applications and final census. The timing of contract delivery assumes that State Insurance Department filing is not required.
3. Based on minimum of 1,000 calls annually into our National Accounts phone queue
4. Subject to minimum claims counts by product to ensure a credible sample size (STD 30, LTD 12, Life 10). Non credible results are shown in *Italics*.



One Sun Life Executive Park  
Wellesley Hills, MA 02481

[www.sunlife.com/us](http://www.sunlife.com/us)

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states except New York, under Policy Form Series 15-GP-01, 93P-LH, 98P-ADD, 07P-LH-PT/07C-LH-PT, 01P-ADD-PT/01C-ADD-PT, GP-A, GC-A, 16-DEN-C-01, 16-DI-C-01, 12-GP-01, 12-DI-C-01, 13-ADD-C-01, 15-ADD-C-01, 12-GPPort-P-01, 13-ADDPort-C-01, 15-LF-C-01, 15-LFPort-C-01, 12-STDPort-C-01, 16-VIS-C-01, TDBPOLICY-2006, and TDI-POLICY. In New York, group insurance policies are underwritten by Sun Life and Health Insurance Company (U.S.) (Lansing, MI) under Policy Form Series 15-GP-01, 13-GP-LF-01, 13-LF-C-01, 13-GP-LH-01, 15-LF-GP-01, 13-ADD-C-01, 13-LTD-C-01, 13-STD-C-01, 06P-NY-DBL, GP-A, GC-A, 12-GPPort-01, 13-LFPort-C-01, 13-ADDPort-C-01, and 12-STDPort-C-01. Product offerings may not be available in all states and may vary depending on state laws and regulations. Sun Life reserves the right to discontinue any service that is not insurance at any time. All products, brands, and names are the property of their respective owners. The group insurance policies described in this advertisement do NOT provide basic hospital, basic medical, or major medical insurance. Product offerings may not be available in all states and may vary depending on state laws and regulations.

NATP-7885a

SLPC 29168 08/18 (exp. 08/20)

# Sorting through the numbers

PPO networks have become quite the numbers game. These days it seems each carrier counts their network a different way. Need help sorting through all the numbers? We can help!

## Let's start by defining the common terminology.

Terminology	Counting method
Access points/referable locations	Each provider at each location where they practice
Unique providers	Each provider is counted once, regardless of the number of locations
Unique locations	Each location is counted once, regardless of the number of providers at each location

### Here's an example.

Simon and Amy have a practice together with three different offices. Their counts would be:

Access points/ referable locations	Unique providers	Unique locations
6	2	3

As you can see the numbers can vary depending on how they are being counted. When you are comparing networks be sure to compare apples to apples to get the best picture. To get an even better picture ask a carrier for their totals at the "practicing location" level. For each of the categories above they can tell you how many providers or locations had claims activity in the past 12 months, which is an indication that the dentist is actually at the given location.

## Here are the numbers for our Sun Life Dental Network<sup>1</sup>:

Access points/ referable locations	Unique providers	Unique locations
486,154 total	136,111 total	97,279 total
202,276 practicing access points	110,944 practicing unique providers	85,426 practicing unique locations

1. Netminder data as of September 2019. For more information, please visit [www.netminder.com](http://www.netminder.com). Nationwide counts are state level totals.

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**Certificate of Foreign Person's Claim That Income Is  
Effectively Connected With the Conduct of a Trade or  
Business in the United States**

OMB No. 1545-1621

▶ Section references are to the Internal Revenue Code.

▶ Go to [www.irs.gov/FormW8ECI](http://www.irs.gov/FormW8ECI) for instructions and the latest information.

▶ Give this form to the withholding agent or payer. Do not send to the IRS.

**Note:** Persons submitting this form must file an annual U.S. income tax return to report income claimed to be effectively connected with a U.S. trade or business. See instructions.**Do not use this form for:****Instead, use Form:**

- A beneficial owner solely claiming foreign status or treaty benefits . . . . . W-8BEN or W-8BEN-E
- A foreign government, international organization, foreign central bank of issue, foreign tax-exempt organization, foreign private foundation, or government of a U.S. possession claiming the applicability of section(s) 115(2), 501(c), 892, 895, or 1443(b) . . . . . W-8EXP

**Note:** These entities should use Form W-8ECI if they received effectively connected income and are not eligible to claim an exemption for chapter 3 or 4 purposes on Form W-8EXP.

- A foreign partnership or a foreign trust (unless claiming an exemption from U.S. withholding on income effectively connected with the conduct of a trade or business in the United States) . . . . . W-8BEN-E or W-8IMY

- A person acting as an intermediary . . . . . W-8IMY

**Note:** See instructions for additional exceptions.**Part I Identification of Beneficial Owner** (see instructions)

<b>1</b> Name of individual or organization that is the beneficial owner <u>SUN LIFE ASSURANCE COMPANY OF CANADA</u>	<b>2</b> Country of incorporation or organization <u>CANADA</u>
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**3** Name of disregarded entity receiving the payments (if applicable)

<b>4</b> Type of entity (check the appropriate box): <input type="checkbox"/> Partnership <input type="checkbox"/> Simple trust <input type="checkbox"/> Government <input type="checkbox"/> Grantor trust <input type="checkbox"/> Private foundation <input type="checkbox"/> International organization	<input type="checkbox"/> Individual <input type="checkbox"/> Complex trust <input type="checkbox"/> Central bank of issue	<input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Estate <input type="checkbox"/> Tax-exempt organization
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**5** Permanent residence address (street, apt. or suite no., or rural route). **Do not use a P.O. box or in-care-of address.**1 YORK STREET

City or town, state or province. Include postal code where appropriate.

TORONTO, ONTARIO M5J 0B6

Country

CANADA**6** Business address in the United States (street, apt. or suite no., or rural route). **Do not use a P.O. box or in-care-of address.**ONE SUN LIFE EXECUTIVE PARK, SC 3331

City or town, state, and ZIP code

WELLESLEY, MASSACHUSETTS 02481 USA

<b>7</b> U.S. taxpayer identification number (required—see instructions) <input type="checkbox"/> SSN or ITIN <input checked="" type="checkbox"/> EIN <u>38-1082080</u>	<b>8</b> Foreign tax identifying number <u>105071005RC0002</u>
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<b>9</b> Reference number(s) (see instructions)	<b>10</b> Date of birth (MM-DD-YYYY)
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**11** Specify each item of income that is, or is expected to be, received from the payer that is effectively connected with the conduct of a trade or business in the United States (attach statement if necessary). INTERESTANDSEE ATTACHED STATEMENT**Part II Certification****Sign  
Here**

Under penalties of perjury, I declare that I have examined the information on this form and to the best of my knowledge and belief it is true, correct, and complete. I further certify under penalties of perjury that:

- I am the beneficial owner (or I am authorized to sign for the beneficial owner) of all the payments to which this form relates,
- The amounts for which this certification is provided are effectively connected with the conduct of a trade or business in the United States,
- The income for which this form was provided is includible in my gross income (or the beneficial owner's gross income) for the taxable year, and
- The beneficial owner is not a U.S. person.

Furthermore, I authorize this form to be provided to any withholding agent that has control, receipt, or custody of the payments of which I am the beneficial owner or any withholding agent that can disburse or make payments of the amounts of which I am the beneficial owner.

I agree that I will submit a new form within 30 days if any certification made on this form becomes incorrect.

Christine PetersenRBruzzese

Signature of beneficial owner (or individual authorized to sign for the beneficial owner)

C Petersen / R Bruzzese

Print name

01-02-2018

Date (MM-DD-YYYY)

☒ I certify that I have the capacity to sign for the person identified on line 1 of this form.



## Statement of Exemption from Withholding Tax

### W-8ECI Attachment

Sun Life Assurance Company of Canada (E.I.N. 38-1082080) is a foreign insurance company operating a U.S. Branch that files a National Association of Insurance Commissioners (“NAIC”) annual statement with the insurance department of the state of Michigan. All payments to the U.S. Branch of Sun Life Assurance Company of Canada are presumed to be effectively connected with the conduct of a trade or business within the United States and backup withholding is not required.

Please refer to the instructions for Form W-8ECI which states that payments to a U.S. Branch of certain foreign persons is presumed to be effectively connected with the conduct of a trade or business within the United States even if the foreign person does not give you a Form W-8ECI. Branches to which this presumption applies included a U.S. branch of a foreign insurance company required to file a NAIC annual statement with the insurance department of a state, territory, or the District of Columbia.

Handwritten signature of Christine Peltus in black ink.

\_\_\_\_\_  
VP, Global Tax Operations

01-02-2018

\_\_\_\_\_  
Date

Handwritten signature of R. B. Bugg in black ink.

\_\_\_\_\_  
AVP, Canadian Tax

01-02-2018

\_\_\_\_\_  
Date