Combined Evidence of Coverage and Disclosure Form

This combined Evidence of Coverage and Disclosure form constitutes only a summary of the dental plan. The Subscriber Agreement must be consulted to determine the exact terms and conditions of coverage.

You Can Afford To Smile With Unum Dental HMO Plan!

The Evidence of Coverage and Disclosure form discloses the terms and conditions of coverage for the Plan and should be reviewed completely and carefully prior to enrollment in the Plan. Individuals with special health care needs should carefully read those sections that apply to them. To request an additional Evidence of Coverage and Disclosure form or the Group Subscriber Agreement, please contact the Plan at:

UNUM DENTAL HMO PLAN
P.O. Box 318240
Baton Rouge, LA 70831
1-800-937-3400

Facilities

The Plan's participating providers are open during normal business hours. For details regarding a provider's days and hours of business, call or write to the provider or the Plan.

The Plan's telephone number is (800) 937-3400, which should be used in case of dental emergency when your provider cannot be reached. The Plan cannot assist members with medical (non-dental) conditions or emergencies. Members should contact their medical doctor or medical plan to receive care for medical (non-dental) conditions. In the event of a medical emergency, please contact the appropriate medical emergency service for your area.

Definitions

The words and phrases defined below have meanings other than those attributed to them by the public in general usage.

Benefits and Coverage means dental care services available under the Subscriber Agreement in which the member is enrolled.

Cancelled, not renewed or nonrenewal means termination of coverage initiated by the plan during or at the conclusion of the contract term, but does not include the following:

- Voluntary termination at the request of the enrollee or subscriber.
- Termination for failure to satisfy any statutory or regulatory eligibility requirements under federal or state law.
- Exhaustion of any time-limited coverage provided by federal or state law, including, but not limited to, continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 or Cal-OCBRA.
- Prospective termination for failure to satisfy eligibility requirements under a group plan contract, as follows:
    1. Time-based employment requirements, including, but not limited to, a reduction in work hours;
    2. Marital or registered domestic partner status;
    3. Attainment of limiting age by dependent child;
    4. Group participation requirements; or
    5. Service-are requirements.

Copayment means a fee charged to a member, which is payable directly to the dentist at the time of service.

Cosmetic Dentistry means any dental procedure that is performed purely for cosmetic purpose and where there is no restorative value.

Dependent means the spouse, domestic partner and children of a member, as defined herein under the section entitled eligibility.

Emergency Dental Services means services to alleviate severe pain, or other symptoms, or to diagnose and treat an illness or injury that a reasonable person under the circumstances would believe could lead to serious jeopardy or

impairment of health if not treated immediately.

General Practitioner/General Dentist means a dentist who practices general dentistry who does not hold himself out to be a specialist in a particular field of dentistry.

Grace Period means a period of at least 30 consecutive days beginning the day the Notice of Start of Grace Period is dated. The Grace Period may not begin sooner than the day after the last date of paid coverage and shall extend through the thirtieth (30^{th}) day after the last date of paid coverage.

Grievance means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative, subscriber, or group contract holder. It may also include a written or oral expression of dissatisfaction by an enrollee, subscriber or group contract holder who believes their plan contract, enrollment or subscription has been or will be improperly cancelled, rescinded or not renewed. Where the plan is unable to distinguish between a grievance and inquiry, it shall be considered a grievance. Grievances may be addressed to the plan and/or the Dental Director

Group Contract Holder or **Group Subscriber** means an employer that contracts with a plan to provide dental services to members or subscribers.

Member means a subscriber or eligible dependent who is enrolled in the Plan.

Optional Dentistry means any dental procedure, which is unnecessary to the dental health of the patient consistent with professionally recognized standards of dental care.

Plan means Starmount Managed Dental of California Inc. dba Unum Dental HMO Plan.

Plan Provider means a dentist licensed to practice dentistry in the State of California and is under contract with the Plan.

Prepayment Fee means the amount payable each month on a prepayment basis by a member to obtain benefits provided under the Subscriber Agreement.

Rescission or rescind means retroactive cancellation of coverage.

Service Area means the geographical area in which the Plan provides dental services. The Plan's current service area includes the following forty-two counties: Alameda, Napa, Santa Clara, Butte, Nevada, Santa Cruz, Colusa, Orange, Shasta, Contra Costa, Placer, Siskiyou, El Dorado, Riverside, Solano, Fresno, Sacramento, Sonoma, Glenn, San Benito, Stanislaus, Kern, San Bernardino, Sutter, Kings, San Diego, Tehama, Los Angeles, San Francisco, Tuolumne, Madera, San Joaquin, Tulare, Mariposa, San Luis Obispo, Ventura, Merced, San Mateo, Yolo, Monterey, Santa Barbara, and Yuba.

Specialist means a dental specialist, board certified or board eligible, who is responsible for the specialized dental care of a member in the specific field of endodontics, orthodontics, periodontics, pedodontics, prosthodontic or oral surgery. The member is referred by a Plan provider for specialty dental care only with the Plan's approval.

Subscriber means an eligible employee or someone who is otherwise eligible under the requirements of the Subscriber Agreement and who is enrolled in the Plan.

Prepayment Fees

Upon initial enrollment of a member, prepayment fees (premiums) shall be due and payable on the day of enrollment. Prepayment fees, if monthly for group plans, must be received by the Plan on or before the last day of the month for each month of service. Yearly prepayment of fees for individual plans must be received on or before the last day of the month for coverage beginning the first day of the following month. All payments will be sent to the Plan P.O. Box 318240, Baton Rouge, LA 70831.

Please refer to the "***Revision of Rates***" provision for the Plans authority to change the fees during the term of the contract.

Refund Policy

Your enrollment is for a continuous period of 12 months. You may, however, cancel your policy within the first thirty (30) days after enrollment and receive a full refund, PROVIDED, that you have not used your benefits during that period.

Coverage Commencement Date

Coverage commences on the first day of the month for all members and their dependents that are enrolled when the Plan starts. Coverage commences on the first day of the month, following collection of the fee by the Plan.

Identification Cards

Upon an individual's membership in the Plan, an identification card will be issued. Possession of an identification card does not guarantee the bearer of the card any dental services or other benefits under the Subscriber Agreement. To be eligible and receive such services and benefits, the holder of the card must in fact, be an eligible member whose subscriber fees have been paid in full. Any non-eligible individual receiving dental services will be charged the usual and customary fees of the dental office rendering those services.

Eligibility

The covered services of this plan are available to members as long as they live or work in the Plan's service area. Provisions that apply to all members who are enrolled in the Plan:

1. Dependents include newborn infants; whose coverage commences from the moment of birth.
2. Adopted, foster, and stepchildren whose coverage commences from the date of placement.
3. Children under 26 years of age.

Coverage continues while a dependent child is incapable of self-sustaining employment by reason of physically or mentally disabling, injury, illness, or condition and is chiefly dependent upon member for support and maintenance. The Plan shall notify the subscriber that the dependent child's coverage will terminate upon attainment of the limiting age unless the subscriber submits proof of the criteria described above to the plan within 60 days of the date of receipt of the notification. The Plan shall send this notification at least 90 days prior to the date the child attains the limiting age. Upon receipt of a request by the subscriber for continued coverage of the child and proof of the criteria described above, the plan shall determine whether the child meets that criteria before the child attains the limiting age. If the plan fails to make the determination by that date, it shall continue coverage of the child pending its determination

The Plan will not discriminate against any member based on age, race, religion, national origin, sex, or sexual orientation or solely on the grounds that such person filed a complaint.

Telehealth

The Plan compensates dental providers for the diagnosis, consultation, or treatment of a member via telehealth on the same basis and to the same extent that the Plan would compensate the same covered benefit delivered in-person.

Other Charges

A Schedule of Covered Benefits is provided to each member, which lists the dental procedures for which the member is required to pay the provider and the amount of the copayment which the provider is allowed to charge for specific procedures set forth under the column titled "Copayment". The Copayment is payable at the time such procedures are rendered by the provider. Procedures provided by a Specialist must be pre-authorized by the Plan (see section "Referrals to Specialist). The member is required to pay their copayment to the Specialist at the time of service. The Plan shall not assign sums payable to a Member by the Plan. If a dental procedure is not covered, the procedure will not be listed as a covered benefit. If a dental procedure is covered at no charge, the plan shall list the copayment as [$0.] or "No Charge".

The Plan compensates general dental providers based on the number of members enrolled in the office. This compensation is not based on the level of patient utilization. Additional compensation is provided by the member's copayment at the time that specific procedures are provided to the patient.

Any procedure that is not listed and is made available by the provider, shall be at the usual and customary fee of the provider. These charges are not the responsibility of the Plan and shall be paid by the member directly to the provider rendering the service.

If the member wishes to know more about these issues the member can request additional information from the plan, the provider, or the provider's group. In the event of termination of coverage, the member shall be responsible for the remaining Copayment balance due to the Plan orthodontist. The member remains entitled to receive orthodontic care from the Plan orthodontist until orthodontic care is complete.

Revision of Rates

The Plan reserves the right to revise or change the prepayment fees payable, under the Subscriber Agreement, once a year. Such revisions or changes of the prepayment fees shall become applicable for all members on the effective date of the revision or change.

The Plan shall give at least 60 days' notice to the subscriber on any revision of the rates. Plan's notice is considered delivered when mailed to the subscriber at the address shown on the records of the Plan.

Choice of Physicians and Providers

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

Each member must select, from the Plan's panel of dentists, a provider that he or she wishes to use for the dental services provided herein. The member is required to identify his or her choice of provider by designating the provider name and office number on the enrollment card.

If the selected provider is no longer participating in the Plan, the company will assign the member to the next closest available office. Thereafter, to obtain dental care, the member must contact the selected provider and go to the same provider at all times in order to receive services provider herein.

By statute, every contract between the Plan and its providers must state that, in the event the Plan fails to pay the Provider, the subscriber shall not be liable for any sums owed to the Provider by the Plan. Copayments and fees for services not covered by the Plan do not fall within the statute.

Liability of Subscriber or Enrollee for Payment

Member is required to pay the fees charged by a non-contracting provider, if they chose the services of a dentist or dental specialist outside the Plan's network of providers. When the services of a dental specialist is required, the member may only go to the specialist the member is referred to by the member's provider, with the approval of the Plan. Should the Plan fail to pay non-contracting providers, the member may be liable to the non-contracting provider for the cost of services.

Timely Access to Care

Participating plan dentist have agreed to provide the utmost service by offering enrollees appointments for covered dental services that are not to exceed the following timeframes:

- Non-urgent appointments shall be offered within 36 business days;
- Preventative appointments shall be offered within 40 business days;
- Urgent appointments shall be offered within 72 hours consistent with the members individual needs; and
- Emergency care, 24 hours a day 7 days a week

If for any reason an appointment is cancelled, re-scheduling will follow the same Appointment Scheduling Standards.

Should the member need interpretation services when scheduling an appointment please contact the Plan's customer service department at **(800) 937-3400** for assistance.

Emergency Dental Care

Emergency dental care is available to a member 24 hours a day, 7 days a week, through the provider's office that the member selected. In the event a member requires emergency dental care after-hours or on weekends the member is to contact the assigned provider for instruction on how to proceed. If the member's selected provider is not available, or if the member is out of area and cannot contact the Plan to be directed to another contracted provider the member may go to any dental provider, closest emergency room, or call 911 for assistance, as necessary. The member may have emergency services rendered by any appropriately licensed physician in the location where the emergency occurs. Prior Authorization for emergency dental services or urgent services is not required. The Plan shall reimburse the member for emergency care rendered by a non-participating licensed professional upon presentation of a detailed statement from the treating dentist indicating all services provided. The Plan will reimburse the enrollee up to $50 for emergency pain relief (pain, swelling, bleeding). The member shall be required to submit the detailed statement to the Plan, within 60 days of services rendered. The member is required to return his or her selected provider for further treatment.

Reimbursement Provision

Upon application in writing to Unum Dental HMO Plan, P.O. Box 318240, Baton Rouge, CA 70831, accompanied by a statement from the non-plan provider that emergency palliative treatment was given to the enrollee; the Plan will directly reimburse the subscriber member or the enrollee.

Continuity of Care

If you have been receiving care from a dental care provider, you may have a right to keep your dental care provider for a designated period of time. In the event you are receiving care for an acute condition, care for a newborn child between birth and 36 months or for an authorized surgery or other procedure, you may request the Plan to arrange for the continuation of care from your terminated provider or nonparticipating provider. This policy does not apply to a newly covered enrollee covered under an individual subscriber agreement.

You must make a specific request to continue under the care of your current provider. We are not required to continue your care with that provider if you are not eligible under our policy or if we cannot reach agreement with your provider on the terms regarding your care in accordance with California law.

Please contact this Plan's customer service department at **(800) 937-3400**, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone or at its toll-free number, 1-888-466-2219, or at a TDD number for the hearing impaired at **1-877-688-9891**, or online at **www.dhmc.ca.gov**. You may also obtain a copy of our policy on continuation of care from our customer service department.

Transferring Providers

In the event a member is dissatisfied with his or her selected provider and wishes to transfer to another provider, the member may do so by calling the Plan immediately. Generally, the transfer will be effective on the first day of the next month. Care received from a non-participating dentist or without the authorization of the Plan will be the full financial responsibility of the member at the dentist's usual and customary rate for service. All enrollee fees and copayments must be paid prior to transferring to a new provider office.

Referrals to Specialist

If the member's Plan provider determines that the services of a specialist are required for a specific treatment, the Primary General Dentist will submit all required documentation to the Plan. The Plan will refer the member to a specific specialist by forwarding a letter of authorization to the member and a copy to the member's provider. Pre-authorizations are based on member eligibility and medical necessity. If an urgent referral is determined, the member's provider will contact the Plan and immediate arrangements will be made for specialty treatment (see section "Prior Authorization Timeframes"). Prior Authorization for out-of-area emergency dental services or urgent services is not required (see section "Emergency Dental Care")

Please Note: If an enrollee receives services from a dental specialist without the Plan's approval or an enrollee's general dentist refers an enrollee to a dental specialist without the Plan's approval, the enrollee will not receive the negotiated fee (see section "Copayment and Other Charges") and will be fully responsible for the specialist's Usual, Customary and Reasonable (UCR) fee."

Prior-Authorization Timeframes

The Plan will approve or deny requests by providers for authorization, in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 5 business days from the plan's receipt of the information reasonably necessary and requested by the Plan to make the determination.

The Plan will approve or deny urgent requests for authorization made by providers within 72 hours after the Plan's receipt of reasonably necessary information requested by the Plan. During normal business hours, the Plan will make every effort to approve, or deny urgent requests within 24 hours.

In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination and shall be communicated to the provider.

The Plan notifies enrollees in writing of decisions to deny authorization requests within two (2) business days and providers within 24 hours of making the decision.

Second Opinions

Members may request a second opinion from an appropriately qualified health care professional regarding treatment recommended by the treating contracting dentist or work that is desired by the member. The second opinion request may be made orally or in writing to the Plan. The Plan Member Services Department and the Dental Director will review the request. There shall be no additional cost to the member beyond the ordinary office copayment if the second opinion is authorized and received from a Plan dentist. If the member requests a second opinion from a dentist who is not contracted by the Plan, the member must provide an explanation why a Plan provider cannot perform the second opinion. If a Plan provider is unavailable, the member may see a non-contracted provider and the Plan will cover the cost of a second opinion up to $50.00. The member is financially responsible to pay for all costs over $50.00 for a second opinion by a non-Plan dentist. Decisions to approve or deny request for second opinions, are based on membership eligibility and benefit availability, not medical necessity. The Plan's response shall be made in a timely fashion appropriate for the nature of the enrollees' condition, not exceed 5 business days, 72 hours for serious conditions or 24 hours for emergencies. For purposes of this section an "appropriately qualified healthcare professional" is a licensed dentist with experience in the type of procedure which is the subject of the Second Opinion.

The member shall have access to the Plan's grievance system at all times. Members may request a complete second opinion policy by contacting the Plan either orally or in writing.

Termination of Benefits

An individual or group subscriber may request to voluntary cancel their benefits. Any procedures from an existing treatment plan shall be completed by a Plan provider, given that the treatment plan was effective prior to the termination/cancellation incident date. The effective date of such termination or cancellation will be the last day of the current month.

Reasons for Termination, Cancellation or Rescission of Benefits

The individual or group subscriber agreement and coverage thereunder may be cancelled, terminated or rescinded for the following reasons:

1. Failure to pay premiums;
2. Fraud or intentional misrepresentation of a material fact on the signed enrollment application form with respect to eligibility for coverage and/or benefits under the subscriber agreement. This includes but is not limited to Fraud or deception in the use of the services or facilities of the Plan or knowingly permitting such fraud or deception by another. If the subscriber agreement is rescinded for fraud or deception, the agreement will be void upon receipt of notification.

3. Material breach by the individual Subscriber or Group Subscriber of the terms in the subscriber agreement, the Evidence of Coverage, the enrollment agreement or any other document that forms a part of the subscriber agreement.

4. The Plan ceases to provide or arrange for the provision of dental benefits for new plan contracts in the individual or group market.

5. The Plan withdraws the dental health benefit plan from the market.

6. If the individual or group subscriber agreement is terminated or cancelled for reasons other than non-payment, the coverage under the agreement will end, effective at midnight on the thirtieth (30^{th}) day after the notice of cancellation is delivered.

7. Upon termination of the Member's benefits, the Member and his or her dependents shall continue to be eligible for dental care at Member's selected office until the last day of the month in which the Member's termination occurred.

Process for Termination, Cancellation, or Rescission

By the Plan: The Plan will not terminate, cancel or rescind the subscriber agreement or coverage thereunder unless the Plan provides prior written notice to the Individual or Group Subscriber.

For terminations, cancellations or rescissions due to the Individual or Group Subscriber's failure to make a premium payment by the due date, the Plan shall send a Notice of Start of Grace Period to the Individual or Group Subscriber, notifying them that a payment delinquency has triggered a grace period starting from the day the Notice of Start of Grace Period is dated. If the cancellation is based on nonpayment of premium, the effective date of cancellation will be no earlier than the day after the last day of the Grace Period. A Notice of End of Coverage will be sent after the date coverage ends, and no later than (5) five calendar days after the date coverage ended. In the event of cancellation for nonpayment where premium is not paid by the end of the Grace Period, the Plan will continue to provide coverage for the duration of the Grace Period, the Individual Subscriber or Group Subscriber will remain responsible for unpaid premium, copayments, coinsurance and deductibles as applicable, and coverage will be cancelled prospectively after the Grace Period.

For all other terminations, cancellations or rescissions:

- For Fraud or intentional misrepresentation of material fact, the Plan will send a Notice of Termination, Cancellation, or Rescission to the Individual or Group Subscriber at least 30 days before the cancellation date.
- The Plan will send a Notice of Termination, Cancellation, or Rescission to the Individual or Group Subscriber at least 30 days before the cancellation date in the case of:
    1. For Individual Subscribers, the Individual Subscriber no longer resides, lives, or works in the Plan's service area, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals;
    2. For Group Subscribers, violation of a material contract provision relating to employer contribution or group participation rates by the contract holder or employer.
- If the Plan ceases to provide or arrange for the provision of dental benefits for new plan contracts in the individual or group market, the Plan will send a Notice of Termination, Cancellation, or Rescission to the Individual or Group Subscriber at least 180 days before the cancellation date.

- If the Plan withdraws from the dental benefit market, the Plan will send a Notice of Termination, Cancellation, or Rescission to the Individual or Group Subscriber at least 90 days before the cancellation date.

By Group Subscriber: This agreement may be voluntarily cancelled by the Group Subscriber. The Group Subscriber shall mail written notice of cancellation to each Subscriber. The date of cancellation will be no earlier than 15 days from the date the notice was sent. The Group Subscriber shall have 10 days from the mailing date to provide, the Plan, proof of cancellation notice to each Subscriber. The Plan will require the Group Subscriber to send a letter, return-receipt requested, to the Plan stating the dissemination of written notice to each Subscriber at a specified address and the date thereof. Coverage will continue under the Group contract through the last date of paid coverage. If the Group Subscriber does not comply with this provision on written notice, its notice of cancellation will be void.

By Individual Subscriber: The Individual Subscriber may voluntarily cancel this agreement by promptly mailing a written notice of cancellation to the Plan's Processing Department at *P.O. Box 318240, Baton Rouge, LA 70831*. The Subscriber Agreement is effective for a continuous period of twelve (12) months. However, the Subscriber may cancel the Subscriber Agreement within the first thirty (30) days of the effective date and receive a full refund, provided, that benefits have not been used during that period.

Review by Director of the Department of Managed Health Care

A Member, Subscriber, Group Subscriber, enrollee or group contract holder who alleges that an enrollment or subscription has been or will be improperly cancelled, terminated, rescinded, or not renewed may request a review by the Director of the Department of Managed Health Care who maintains a toll free telephone number at **1-877-632-9095.** The hearing and speech impaired may use the California Relay Service's toll-free telephone number at **877-688-9891** to contact the Department. Please refer to the "***Complaints and Grievances***" provision for detailed information regarding grievances.

Renewal Provisions

Conditions for Renewal or Reinstatement: The Plan may cancel for non-payment if the proper prepaid or periodic payments are not received before the last day of the grace period, as specified in the Notice of Grace Period. If payment is received after the account has been cancelled, the Plan may reinstate the enrollee.

Former Members of the Plan will have coverage and entitlements renewed upon again becoming eligible. To be eligible the Member must complete the enrollment application and forward the signed copy to the Plan. The Plan will review the enrollment application materials and contact the applicant within ten (10) days of receipt.

Optional Individual Continuation of Benefits

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) and the California Continuation Benefits Replacement Act (or Cal-COBRA, pertaining to group contract holders or group subscribers with two to 19 employees), both require that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You may be entitled to continue coverage under this plan, at your expense, if certain conditions are met. The period of continued coverage depends on the Qualifying Event and whether the member or subscriber is covered under federal COBRA or Cal-COBRA.

DEFINITIONS SPECIFIC TO THIS SECTION: Key terms for both federal and Cal-COBRA are defined below and pertain to this section "Optional Individual Continuation of Benefits" only.

Qualified Beneficiary means:

1. Members or subscribers who are enrolled in the Unum Dental HMO Plan on the day before the Qualifying Event, or
2. A child who is born to or placed for adoption with you during the period of continued coverage provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Qualifying Event #1: The termination of employment (other than termination for gross misconduct) or the reduction of work hours, by your employer:
Qualifying Event #2**:** Your death;
Qualifying Event #3**:** Your divorce or legal separation from your spouse;
Qualifying Event #4**:** Your dependent's loss of dependent status under the plan; and
Qualifying Event #5**:** As to your dependents only, your entitlement to Medicare.

You or Your means the member, or subscriber.

PERIODS OF CONTINUED COVERAGE UNDER FEDERAL COBRA: Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event #1 occurs.

This 18-month period can be extended for a total of 29 months, provided:

1. A determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
2. Notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 20 days after the date of the final determination that the disabled individual is no longer disabled. You must notify your group contract holder or group subscriber within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event, your dependents who are Qualified Beneficiaries experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event #1.

Your dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4, or 5.

Under federal COBRA law only, when a group contract holder or group subscriber has filed for bankruptcy under Title 11, United States Code, benefits may be substantially reduced or eliminated for retired members, subscribers and their dependents, or the surviving spouse of a deceased retired member or subscriber. If this benefit reduction or elimination occurs within one year before or one year after filing, it is considered a Qualifying Event. If the member or subscriber is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The member or subscriber's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the member or subscriber's death.

PERIODS OF CONTINUED COVEAGE UNDER CAL-COBRA (groups of 2-19): In the case of Cal-COBRA, Unum Dental HMO Plan will act as the administrator. Notification and premium payments should be made directly to Unum Dental HMO Plan. Notifications should be delivered by first-class mail, certified mail, or other reliable means of delivery.

Individuals who are eligible for coverage under the federal COBRA law are not eligible for coverage under Cal-COBRA. The group contract holder or group subscriber must notify Unum Dental HMO Plan in writing within 30 days of the date they become subject to COBRA.

Qualified Beneficiaries may continue coverage for 36 months following the month in which Qualifying Events 1, 2, 3, 4, or 5 occur.

If, during the 36-month continuation period resulting from Qualifying Event #1, the Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to be disabled on the date of the Qualifying Event or became disabled at any time during the first 60 days of the continuation of coverage; and notice of the determination is given to the group contract holder or group subscriber during the initial period of continuation coverage and within 60 days of the date of the social security determination letter, the Qualified Beneficiary may continue coverage for a total of 36 months following the month in which Qualifying Event #1 occurs.

This period of coverage will end on the first of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. The Qualified Beneficiary must notify the group contract holder or group subscriber, or administrator within 30 days of any such determination.

If, during the 36-month continuation period resulting from Qualifying Event #1, the Qualified Beneficiary experiences Qualifying Events 2, 3, 4, or 5, he or she must notify the group contract holder or group subscriber within 60 days of the second qualifying event and has a total of 36 months continuation coverage after the date of the date of the first Qualifying Event.

Unum Dental HMO Plan shall notify the member or subscriber of the date his or her continued coverage will terminate. This termination notification will be sent during the 180-day period prior to the end of coverage.

ELECTION OF CONTINUED COVERAGE: A Qualified Beneficiary will have 60 days from a Qualifying Event to give Unum Dental HMO Plan written notice of the election to continue coverage.

Upon written notice, Unum Dental HMO Plan will provide a Qualified Beneficiary with the necessary Benefits information, monthly premium charge, enrollment forms and instructions to allow election of continued coverage.

Failure to provide this written notice of election to Unum Dental HMO Plan within 60 days will result in the loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to Unum Dental HMO Plan, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in the loss of the right to continue coverage and any premiums received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS: The Benefits under the continued coverage will be the same as those provided to the actively employed member or subscribers and their dependents who are still enrolled in the dental plan. If the group contract holder or group subscriber changes the coverage for actively employed members or subscribers, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE: A Qualified Beneficiaries coverage will terminate at the end of the month in which any of the following events first occur:

1. The allowable number of consecutive months of continued coverage is reached;
2. Failure to pay the required premiums in a timely manner;
3. The group contract holder or group subscriber ceases to provide any group dental plan to its members or subscribers;
4. The individual moves out of the plan's service area;
5. The individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as a member or subscriber, or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this plan; or
6. Entitlement to Medicare.

Once continued coverage ends, it cannot be reinstated.

TERMINATION OF THE GROUP CONTRACT HOLDER OR GROUP SUBSCRIBER DENTAL CONTRACT: If the dental contract between the group contract holder or group subscriber and Unum Dental HMO Plan terminates prior to the time that the continuation coverage would otherwise terminate, the group contract holder or group subscriber shall notify a Qualified Beneficiary either 30 days prior to the termination or when all members or subscribers are notified, whichever is later, of the ability to elect continuation of coverage under the group contract holder's or group subscriber's subsequent dental plan, if any. The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the Unum Dental HMO Plan had such plan with the former group contract holder or group subscriber not terminated. The group contract holder or group subscriber shall notify the successor plan in writing of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in and payment of premiums to the new group benefit plan.

OPEN ENROLLMENT CHANGE OF COVERAGE: A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the group contract holder or group subscriber has contracted with another plan to provide coverage to its actively employed members or subscribers. The continuation coverage under the

other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained under the Unum Dental HMO Plan.

Public Policy Committee

The Plan's Public Policy body consists of the Board of Directors of the Plan pursuant to the Plan's Public Policy Participation policy. As required by regulation, one third of the Board consists of Plan subscribers. In determining the public policy of the Plan, the Board may consider any relevant information that reflects on the comfort, dignity and convenience of Plan enrollees.

Utilization Review

It shall be the policy of the Plan to collect, monitor and manage the utilization of dental services delivered by contracted dentists and specialists. This will include collection of utilization data from primary care dentists and specialists by the Provider Relations staff; reporting and analysis of collected data by the Dental Director, as well as review of Dental Director recommendations on a quarterly basis by the Quality Assurance Committee.

Complaints and Grievances

Any complaint or grievance should be directed to the Plan at the following address:

Attn: Quality Management Department
P.O. Box 318240
Baton Rouge, LA 70831
(800) 937-3400
www.Unumdentalhmo.com

The Plan's complaint and grievance process is available to a Member, Subscriber, Group Subscriber, enrollee and group contract holder. A form for receiving and processing complaints and grievances is available through the Plan's telephone or address contact information listed above. You may also complete an online grievance form at: www.Unumdentalhmo.com

The Plan maintains a grievance committee to process complaints and grievances. As stated above, forms shall be made available by writing or calling the Plan or are available at the Member's dental office. The Plan will make every effort to investigate the complaint or grievance and respond within thirty (30) days of receipt of the complaint or grievance. In cases of imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function cancellations, recessions, or the nonrenewal of a health care service plan contract or in any other case where it is determined that an earlier review is warranted, a written response by the Plan to the complaint or grievance will be provided no later than three (3) calendar days from the Plan's receipt of the complaint or grievance. The Plan's written response shall contain a clear and concise explanation of the reasons for the Plan's decision.

When a complaint or grievance is urgent, or has not been resolved by the Plan within thirty (30) days of receipt, or has not been resolved to the satisfaction of the complainant or grievant, the complaint or grievance may be submitted by the complainant or grievant to the Department of Managed Health Care for review.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-800-937-3400)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Arbitration

Arbitration of any dispute between the Plan and members involving claims, benefits, contracts, or otherwise regarding disputes which are not adequately resolved by the Plan grievance procedures may be initiated by any party only after the Plan's grievance committee has completed its investigation. All such claims, controversies and disputes shall be submitted to arbitration in accordance with the applicable rules of the American Arbitration Association and judgment of said arbitration may be entered in any court of competent jurisdiction. In the event of extreme financial hardship where the member cannot afford to initiate an arbitration proceeding, the matter will be submitted to the American Arbitration Association for review and if it is determined by that body that such financial hardship exists, the Plan will pay for the cost of the initial arbitration filing. The arbitration award shall be accompanied by a written decision to the parties that indicates the prevailing party, the amount of any award, the reasons for the award and other relevant terms of the award.

Any dispute as to medical malpractice, that is whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, controversy which cannot be resolved by the Plan's Peer Review and appeals process will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process, except as California law provides for judicial review or arbitration proceedings. The member gives up their right to have any dispute decided in a court of law before a jury.

Governing Law

The Plan is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California State Code of Regulations, and any provision required to be in the Subscriber Agreement by either of the above shall bind the Plan whether or not set forth herein.

Language Assistance Program

As a Unum Dental HMO Plan Member you have the right to free language assistance services, including interpretation and translation services. Unum Dental HMO Plan collects and maintains your language preferences, race, and ethnicity so that we can communicate more effectively with our members. If you require spoken or written language assistance or would like to inform Unum Dental HMO Plan of you preferred language, please contact us at (800)937-3400 or at 711 to reach the California Relay Service (CRS).

Como miembro de Unum Dental HMO Plan usted tiene el derecho a los servicios gratuitos de asistencia linguistica, incluyendo los servicios de interpretacion y tradiccion. Unum Dental HMO Plan reune y mantiene las preferencias de idioma, raza y etnicidad para que podamos comunicarnos mas eficazmente con nuestros miembros. Si usted require de traduccion en escrito o interpretacion o si desea informar a Unum Dental HMO Plan de su idioma preferido por favor contactenos al (800) 937-3400 o al 711 para contactarse con el Servicio de Teransmision de California (CRS).

Unum Dental HMO Plan
Benefits and Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(A) Deductibles.	None
(B) Lifetime maximums.	None
(C) Professional services.	The Schedule of Benefits – Appendix 1 provides a complete listing of all covered dental procedures within each category listed below, the associated co-payments, limitations and exclusions. **Category Type** — **Co-Payment** Diagnostic Services [$0-160] Preventative Services [$0-396] Restorative Services [$0-783] Endodontic Services [$0-916] Periodontics Services [$0-1195] Prosthodontic Services [0-1695] Oral and Maxillofacial Surgery [0-1778] Orthodontic Services [Not Covered -2950] Adjunctive General Services [0-566] Member co-payment amount range describes the Members' out-of-pocket costs.
(D) Outpatient services.	Not Covered
(E) Hospitalization services.	Not Covered
(F) Emergency health coverage.	The member may receive a reimbursement of up to $50 per emergency for out-of-area Emergency Services.
(G) Ambulance services.	Not Covered
(H) Prescription drug coverage.	Not Covered
(I) Durable medical equipment.	Not Covered
(J) Mental health services.	Not Covered
(K) Chemical dependency services.	Not Covered
(L) Home health services.	Not Covered
(M) Other.	Not Covered

Limitations and Exclusions on Benefits

Limitations

The following limitations apply:

- Full-mouth X-rays: Limited to one (1) set every three (3) years unless diagnostically necessary.
- Bitewing X-Rays: Two (2) sets in any twelve (12) month period unless diagnostically necessary.
- Sealants: Limited to molars.
- Fluoride: Two (2) in any twelve (12) month period.
- Delivery of removable prosthodontics includes adjustments within six months of delivery date of service.
- Periodontal scaling and root planning: Limited to four (4) quadrants per twenty-four (24) consecutive months in combination with routine prophylaxis.
- Panoramic X-rays: One (1) in any three (3) year period unless diagnostically necessary.
- Prophylaxis: Covered once every six (6) consecutive months.
- Full-mouth debridement is limited to one (1) in a twenty-four (24) month period.
- Cephalometric X-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
- General anesthesia and intravenous sedation is only covered when performed by a contracted oral surgeon and/or pediatric dentist when medically necessary in conjunction with an approved referral.
- Reline of a complete or partial denture: One (1) per denture in any twelve (12) month period, unless dentally necessary.
- Rebase of a complete or partial denture: One (1) per denture in any twelve (12) month period, unless diagnostically necessary.
- Replacement of partial or full dentures are covered once per arch every five (5) years, except when they cannot be made functional through reline or repairs.
- Complete or partial dentures are not to exceed one per arch in a five (5) year period unless necessary due to natural tooth loss where the addition to an existing partial or denture is not feasible.
- Pediatric referrals, if authorized by the Plan, following an attempt by the assigned dental office, are covered only for dependent children through age 6, notwithstanding the age limit, if the service is medically necessary of due to a medical condition.
- Extractions of impacted teeth with no radiographic evidence of pathology (disease). The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists.

Exclusions

The following exclusions apply:

- Treatment of malignancies, cysts, or neoplasm.
- Replacement of lost or stolen prosthetics or appliances including crowns, bridges, partial dentures, full dentures, and orthodontic appliance.
- Periodontal grafting or splinting.
- Orthodontic treatment in process, or extractions for orthodontic purposes.
- Procedures, appliances or restorations whose primary purpose is to change the vertical dimension of occlusion, correct congenital development or medically induced dental disorders including but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specifically listed as a covered benefit on the Plan’s schedule of benefits.
- Precision attachments, stress breakers, magnetic retention or overdenture attachments.

- Any treatment started prior to the member's effective date and/or after the coverage termination date.
- The copayments listed for endodontic procedures do not include the cost of the final restoration.
- Any procedure or treatment unable to be performed in the dental office due to the general health or physical limitation of the member.
- Oral surgery requiring the setting of bone fractures or dislocations, hospitalization, out-patient services, ambulance services, durable medical equipment, mental health services, chemical dependency services, home health services.
- Dispensing of drugs supplied in a dental office.
- Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement under any Worker's Compensation or Occupational Disease Law, even though the Member fails to claim his or her rights to such benefit.
- Cases and/or procedures in which, in the reasonable professional judgement of the attending dentist, a satisfactory result cannot be obtained, or the prognosis is guarded or poor.
- Procedures considered experimental in nature.
- Procedures performed outside of your assigned dental office, unless pre-authorized by the Plan to a dental specialist, except for emergency services as described in section "Emergency Dental Care" of the Evidence of Coverage.
- If two (2) or more covered procedures would appropriately correct a clinical situation, the Plan shall provide coverage for the most appropriate procedure, at its discretion, applying sound clinical reasoning.
- Any treatment requested, or appliances made, which are either not necessary for maintaining or improving dental health or are for cosmetic purposes.
- Consultation and/or evaluations for non-covered services.
- Any procedure not specifically listed in the Evidence of coverage as a covered benefit.

Orthodontic Treatment
Limitations and Exclusions

Limitations

Orthodontic services as listed under Schedule of Benefits are limited to one course of treatment in a lifetime. Orthodontic services are not covered if comprehensive treatment begins before the Member is eligible for benefits under the Plan. If a Member's coverage terminates after the fixed banding appliances are inserted, the member will be responsible for any additional charges incurred for the remaining Orthodontic treatment.

Orthodontic treatment must be provided by an orthodontist who is an in-network participating provider. A referral must first be facilitated by the assigned dental office. If a referral is not approved by the Plan before the Orthodontic treatment begins, the member will be responsible for all charges associated with any Orthodontic treatment.

Exclusion

The following are exclusions of orthodontic coverage:

- Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances damaged due to the neglect of the Member.
- Cephalometric x-rays, unless listed as a covered procedure
- Lost or broken appliances.
- Myofunctional therapy.
- Surgical procedures such as extractions of teeth strictly for the purpose of orthodontia.
- Any jaw surgical procedure related to orthodontia.
- Dental services of any nature performed in hospital or convalescent home or anywhere outside the office or Plan provider, except for emergency services as described in section "***Emergency Dental Care***" of the Evidence of Coverage.
- Dispensing of drugs not normally supplied in an orthodontic practice.
- Treatment related to Temporomandibular Joint Dysfunction or hormonal imbalances.
- Cosmetic or optional/elective alternatives to standard orthodontic treatment such as, clear aligners, ceramic or composite brackets, invisible or lingual braces which includes at-home orthodontics.
- Coverage is up to twenty-four (24) months of comprehensive orthodontic treatment. If treatment that is necessary, goes beyond twenty-four (24) months, the Member will be responsible for additional charges for each additional month(s) of treatment

Appendix 1:

Schedule of Benefits