



Diné Development Corporation

Your Dental Plan

Policy No. 974682 011

Underwritten by Starmount Life Insurance Company

12/18/2024



**Starmount Life
Insurance Company**
8485 Goodwood Blvd.
Baton Rouge, LA 70806

Group Dental Insurance Certificate of Coverage

We welcome you as a customer and are committed to providing quality service. This is your certificate of coverage and describes the benefits to which you are entitled as an Insured. Dental insurance coverage can help ease the costs associated with routine and unforeseen dental procedures.

Policyholder: Diné Development Corporation

Policy Number: 974682 011

Policy Effective Date: January 1, 2025

Policy Anniversary: January 1

Governing Jurisdiction: Arizona

This certificate is issued to you under the policy which is a contract between us and the Policyholder. If the provisions of this certificate are different from the provisions of the policy, the provisions of the policy will govern. A copy of the policy provisions may be made available to you upon request. The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

This certificate provides benefits under the non-participating policy. This certificate contains proof of loss requirements, limitations, exclusions, and other provisions that may reduce benefits or prevent an Insured from receiving benefits under this certificate. Please read your certificate carefully and keep it in a safe place.

Defined terms, provision titles, and section headings have been capitalized.

If you have any questions about the provisions of this certificate, please contact your Employer, or you may contact us at (888) 400-9304 Monday through Friday 8 a.m. to 8 p.m. Eastern Standard Time.

If you still have questions, you may contact the Arizona Department of Insurance at (800) 325-2548.

Your certificate may include notices as required by your state of residence that may impact your benefits. If you have any questions or concerns regarding your state regulations, you may contact the department of insurance in your residence state.

Consumer Complaint Notice

If you are a resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding a claim, premium, or other matters relating to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: <https://www.osi.state.nm.us/ConsumerAssistance/index.aspx>.

Dental Schedule of Benefits	5
<i>High Plan</i>	5
Coverage Type.....	5
Eligible Group(s).....	5
Paying for Coverage.....	5
Deductible	5
Coinsurance	5
Benefit Waiting Period.....	5
Reimbursement for Covered Procedures.....	5
Maximum Benefit.....	6
Certificate Riders	6
<i>Low Plan</i>	6
Coverage Type.....	7
Eligible Group(s).....	7
Paying for Coverage.....	7
Deductible	7
Coinsurance	7
Benefit Waiting Period.....	7
Reimbursement for Covered Procedures.....	7
Maximum Benefit.....	8
Dental Details	9
Start and End of Dental Treatments.....	9
Pre-Estimate.....	9
Dental Details Exclusions and Limitations	10
Exclusions	10
Limitations	10
Coordination of Benefits	12
Carryover Benefit.....	14
Takeover Benefit.....	15

Table of Contents

Start of Coverage [17](#)

End of Coverage [18](#)

Claim Provisions..... [20](#)

General Provisions [23](#)

Glossary [25](#)

High Plan

This section contains provisions which highlight the requirements an Insured may need to satisfy in order to receive benefits. Refer to the Schedule of Covered Procedures or applicable riders to determine class of service for Covered Procedures.

Coverage Type Preferred Provider Organization (PPO) plan.

Eligible Group(s)

All Full-Time Employees in Active Employment in the United States working a minimum of 30 hours per week.

Paying for Coverage

Contributory Coverage

You and your Employer must make premium contributions for your coverage.

Deductible

The Deductible is the amount Insureds must pay each Policy Year before benefits will be payable for Basic and Major Covered Procedures. The Deductible is not applicable to Preventive Covered Procedures.

Deductibles applied for each Insured will count toward satisfying the Per Family Deductible. Once the Per Family Deductible is satisfied, no further Deductibles are required. Only Covered Procedures included in this certificate will count towards satisfying the Deductible.

Per Policy Year	Per Insured
	\$50

Per Policy Year	Per Family
	3x

If an Insured visits an In-Network Provider, the Insured is responsible for paying the In-Network Deductible. If an Insured visits an Out-of-Network Provider, the Insured is responsible for paying the Out-of-Network Deductible.

Coinsurance

Coinsurance is the percentage of the Reimbursement for Covered Procedures paid after any required Deductible has been satisfied. The percentages for which the Policy Pays and Insured Pays for a Covered Procedure are shown below.

Procedure Class	Policy Pays	Insured Pays
Preventive	100%	0%
Basic	80%	20%
Major	50%	50%

Benefit Waiting Period

The Benefit Waiting Period is the period of time during which Insureds must have continuous coverage before benefits for Covered Procedures in the following Procedure Classes become payable.

Procedure Class	Benefit Waiting Period
Preventive	None
Basic	None
Major	None

Reimbursement for Covered Procedures

Reimbursement for Covered Procedures is the lesser of:

- the Providers actual charge; or
- the amount calculated by the applicable Reimbursement Method.

Reimbursement for Covered Procedures is subject to any applicable Deductible, Coinsurance, and Maximum Benefit. Insureds may choose any Provider for treatment and services for Covered Procedures included in this certificate.

Reimbursement Method

In-Network

In-Network Providers have agreed to accept a negotiated reimbursement from us for Covered Procedures in this certificate and any applicable riders. Insureds will typically have less out-of-pocket expenses when a Covered Procedure is performed by an In-Network Provider.

A listing of In-Network participating Providers is available online at www.Unumdentalcare.com or by contacting us directly at (888) 400-9304.

Out-of-Network

Out-of-Network Providers have not entered into an agreement with us to limit the charges for any procedures. Reimbursement for Covered Procedures is based on the Usual and Customary Charges. The Insured is responsible for any remaining charges after we have paid our portion.

Usual and Customary Charge is determined by a review of charges within the general geographic area, made for the same Covered Procedure by Providers of similar training or experience. Usual and Customary Charges are periodically reviewed and updated.

Maximum Benefit

The Maximum Benefit is the total amount of benefits that will be paid for Preventive, Basic, and Major Covered Procedures on an annual basis.

Per Policy Year	Per Insured
	\$2,500

In the event an Insured reaches the Maximum Benefit, the Insured is responsible for all costs associated with all further Covered Procedures.

Certificate Riders

The following riders are attached to this certificate.

Orthodontics Benefit Rider

Dental Schedule of Benefits

Low Plan

This section contains provisions which highlight the requirements an Insured may need to satisfy in order to receive benefits. Refer to the Schedule of Covered Procedures to determine class of service for Covered Procedures.

Coverage Type Preferred Provider Organization (PPO) plan.

Eligible Group(s)

All Full-Time Employees in Active Employment in the United States working a minimum of 30 hours per week.

Paying for Coverage

Contributory Coverage

You and your Employer must make premium contributions for your coverage.

Deductible

The Deductible is the amount Insureds must pay each Policy Year before benefits will be payable for Basic and Major Covered Procedures. The Deductible is not applicable to Preventive Covered Procedures.

Deductibles applied for each Insured will count toward satisfying the Per Family Deductible. Once the Per Family Deductible is satisfied, no further Deductibles are required. Only Covered Procedures included in this certificate will count towards satisfying the Deductible.

Per Policy Year	Per Insured
	\$50

Per Policy Year	Per Family
	3x

If an Insured visits an In-Network Provider, the Insured is responsible for paying the In-Network Deductible. If an Insured visits an Out-of-Network Provider, the Insured is responsible for paying the Out-of-Network Deductible.

Coinsurance

Coinsurance is the percentage of the Reimbursement for Covered Procedures paid after any required Deductible has been satisfied. The percentages for which the Policy Pays and Insured Pays for a Covered Procedure are shown below.

Procedure Class	Policy Pays	Insured Pays
Preventive	100%	0%
Basic	80%	20%
Major	50%	50%

Benefit Waiting Period

The Benefit Waiting Period is the period of time during which Insureds must have continuous coverage before benefits for Covered Procedures in the following Procedure Classes become payable.

Procedure Class	Benefit Waiting Period
Preventive	None
Basic	None
Major	None

Reimbursement for Covered Procedures

Reimbursement for Covered Procedures is the lesser of:

- the Providers actual charge; or
- the amount calculated by the applicable Reimbursement Method.

Reimbursement for Covered Procedures is subject to any applicable Deductible, Coinsurance, and Maximum Benefit. Insureds may choose any Provider for treatment and services for Covered Procedures included in this certificate.

Reimbursement Method

In-Network

In-Network Providers have agreed to accept a negotiated reimbursement from us for Covered Procedures in this certificate and any applicable riders. Insureds will typically have less out-of-pocket expenses when a Covered Procedure is performed by an In-Network Provider.

A listing of In-Network participating Providers is available online at www.Unumdentalcare.com or by contacting us directly at (888) 400-9304.

Out-of-Network

Out-of-Network Providers have not entered into an agreement with us to limit the charges for any procedures. Reimbursement for Covered Procedures is based on an In-Network negotiated fee within the general geographic area, made for the same Covered Procedure. The Insured is responsible for any remaining charges after we have paid our portion.

Maximum Benefit

The Maximum Benefit is the total amount of benefits that will be paid for Preventive, Basic, and Major Covered Procedures on an annual basis.

Per Policy Year	Per Insured
	\$2,000

In the event an Insured reaches the Maximum Benefit, the Insured is responsible for all costs associated with all further Covered Procedures.

The information in this section provides details on the Covered Procedures included in this certificate and any applicable Exclusions and Limitations.

Start and End of Dental Treatments For benefits to be payable, Covered Procedures must be started and completed while an Insured's coverage is in force.

A prosthetic dental appliance installed or delivered after an Insured's coverage ends, may be payable for up to 30 days from the date coverage ended.

Start of Dental Treatments

A dental treatment is considered 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 a 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.

End of Dental Treatments

A dental treatment is considered complete as follows:

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

Pre-Estimate Pre-authorization is not required for any service. If the charge for any treatment is expected to exceed \$300, we recommend that a dental treatment plan be submitted to us by your Provider for a pre-estimate before treatment begins. We may request additional information from an Insured or the Insured's Provider to help us determine benefits payable.

An estimate of the benefits payable will be sent to you and your Provider. The pre-estimate is not a guarantee of the amount we will pay. The pre-estimate process lets an Insured know in advance approximately what portion of the expenses will be covered by benefits. Our estimate may be for a less expensive Alternative Benefit if it will produce professionally satisfactory results.

See the attached Schedule of Covered Procedures for the procedures included in your coverage.

This certificate is subject to all Exclusions and Limitations in this section, unless stated otherwise within a Covered Procedure or a specific provision.

Exclusions

We will not provide benefits for any of the following and we will not pay benefits for a claim that is caused by, contributed to by, or occurs as a result of any of the following:

1. services or supplies not included in the Schedule of Covered Procedures;
2. treatments which are elective or primarily cosmetic in nature and not generally recognized as an accepted dental practice by the American Dental Association, this also includes any replacement of prior elective or cosmetic procedures;
3. experimental or investigational drugs, devices, treatments, or procedures;
4. replacement of a removeable device or appliance that is lost, missing or stolen, and for the replacement of removeable appliances that have been damaged due to abuse, misuse, or neglect. This may include but not be limited to removable partial dentures or denture;
5. replacement of any permanent or removeable device or appliance unless the device or appliance is no longer functional and is older than the limitation in the Schedule of Covered Procedures. This may include but not be limited to bridges, dentures, and crowns;
6. any appliance, service, or procedure performed for the purpose of splinting, to alter vertical dimension or to restore occlusion;
7. any appliance, service, or procedure performed for the purpose of correcting attrition, abrasion, erosion, abfraction, bite registration, or bite analysis;
8. procedures provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, and myofascial pain;
9. orthognathic surgery;
10. prescribed medications, pre-medication, or analgesia;
11. general anesthesia, intravenous sedation, and the services of anesthesiologists or anesthesiologists, except in conjunction with complex oral surgery in which anesthesia is medically necessary;
12. instruction for diet, plaque control, and oral hygiene;
13. war or any act of war, whether declared or undeclared;
14. committing or attempting to commit a felony;
15. being engaged in an illegal occupation;
16. being engaged in an illegal activity;
17. charges for implants unless specified in the Covered Procedures, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments;
18. restorations for teeth, unless necessary due to deterioration from extensive decay or accidental Injury;
19. treatment of malignancies, cysts, and neoplasms;
20. orthodontic treatment;
21. charges for failure to keep a scheduled visit or for the completion of claim forms];
22. procedures which do not offer a favorable prognosis, are not medically necessary, or do not meet generally acceptable standards of care;
23. requests for a duplicate removeable device or appliance;
24. the replacement of 3rd molars;
25. restorations used to restore teeth with micro fractures or fracture lines, undermined cusps, or large existing restorations without over pathology;
26. expenses for Covered Procedures which are covered under your medical plan;
27. expenses compensable under Workers' Compensation or by other employer laws;
28. expenses provided or paid for by any governmental program or law;
29. service or supply rendered by someone who is related to an Insured by blood or by law (e.g., sibling, parent, grandparent, child), marriage (e.g., Spouse or in-law), adoption, or is normally a member of the Insured's household.

Limitations***Alternate Benefit***

There are multiple options for dental treatment, all of which provide acceptable results. An Alternate Benefit may be applied if there is a less expensive Covered Procedure appropriate for the course of treatment, capable of producing acceptable results. When

Dental Details | Exclusions and Limitations

an Alternate Benefit is applied, the less expensive Alternate Benefit is used to determine the amount payable under the certificate.

Other

Multiple restorations on one surface are payable as one surface. Multiple surfaces on a single tooth will not be paid as separate restorations.

On any given day, more than 8 periapical x-rays or a panoramic film in conjunction with bitewings will be paid as a full mouth radiograph.

Coordination of Benefits establishes an order in which Plans pay their claims when an Insured has dental coverage under more than one Plan.

Definitions

The following terms are defined for the purposes of this section:

Allowable Expense is an expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

Plan refers to any Plan, including this one, that provides benefits or services for dental expenses on either a group or individual basis.

Types of Plans include:

- group and blanket insurance;
- self-insured plans;
- prepaid plans;
- government plans;
- plans required or provided by statute (except Medicaid); and
- no fault insurance (when allowed by law).

Primary Plan is the Plan that, according to the rules for The Order of Benefit Determination, pays benefits before all other Plans.

Benefit Coordination

Benefits will be adjusted so that the total payment under all Plans does not exceed 100% of the Insured's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of Coordination of Benefits.

If an Insured's benefits paid under this Plan are reduced due to Coordination of Benefits, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be counted toward any applicable benefit maximum.

The Order of Benefit Determination

When this is the Primary Plan, we will pay benefits as if there were no other Plans. In the event a person is covered by a Plan without a Coordination of Benefits provision, the Plan without the provision will be the Primary Plan.

When a person is covered by more than one Plan with a Coordination of Benefits provision, the order of benefit payment is determined as follows:

Insured Spouse and Insured Children

A Plan which covers a person as a Spouse or Child will pay second to the Plan covering such person as an employee, member, policyholder, subscriber, or retiree.

Children of Parents Not Separated or Divorced

For Children, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the Children for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, we will also use that basis.

Children of Separated or Divorced Parents

If two or more Plans cover Children of separated or divorced parents, benefits for the Children are determined in the order that follows:

- the Plan of the parent who has responsibility for providing insurance as determined by a court order;
- the Plan of the parent with custody of the Child;
- the Plan of the spouse of the parent with custody; and
- the Plan of the parent without custody of the Child.

Children of Parents with Joint Custody

If the joint custody court decree does not specifically state which parent is responsible for the Children's medical expenses, the rules shown for Children of Parents Not Separated or Divorced shall apply.

Persons in Active/Inactive Employment

The Plan which covers the person as an active employee or as that employee's dependent, is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

Longer/Shorter Length of Coverage

When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

Right to Receive and Release Needed Information

You are required to give us information necessary for Coordination of Benefits. Information may be released to or obtained from any other insurance company, organization, or person necessary for Coordination of Benefits. This will not require the consent of, or notice to you or any claimant.

Right to Make Payments to Another Plan

Coordination of Benefits may result in payments made by another Plan that should have been made by us. We have the right to pay any other Plan all amounts it paid which would otherwise have been by us. Amount paid in this manner will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

Right to Recover

Coordination of Benefits may result in overpayments by us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

The Carryover Benefit offers Insureds, upon satisfaction of the Eligibility Requirements, to have a portion of their unused Maximum Benefit carry over to the next Calendar Year. If an Insured reaches their Maximum Benefit, the Carryover Account balance will be used to pay for Covered Procedures.

High Plan**Eligibility Requirements**

Each Insured will be eligible for the Carryover Benefit provided the following requirements are satisfied during the prior Calendar Year:

- at least one cleaning;
- at least one routine exam; and
- the total amount of benefits paid for Preventive, Basic, Major Covered Procedures, in excess of any Deductibles during the prior Calendar Year does not exceed a \$800 threshold limit.

An Insured's eligibility for the Carryover Benefit will be reviewed and determined at the beginning of each Calendar Year.

Carryover Benefit Amount

\$400

Carryover Account Maximum

\$1,500 is the maximum amount an Insured may accumulate in their Carryover Account.

Any Carryover Account balance will no longer be available if there is any break in an Insured's coverage.

Low Plan**Eligibility Requirements**

Each Insured will be eligible for the Carryover Benefit provided the following requirements are satisfied during the prior Calendar Year:

- at least one cleaning;
- at least one routine exam; and
- the total amount of benefits paid for Preventive, Basic, Major Covered Procedures, in excess of any Deductibles during the prior Calendar Year does not exceed a \$800 threshold limit.

An Insured's eligibility for the Carryover Benefit will be reviewed and determined at the beginning of each Calendar Year.

Carryover Benefit Amount

\$400

Carryover Account Maximum

\$1,500 is the maximum amount an Insured may accumulate in their Carryover Account.

Any Carryover Account balance will no longer be available if there is any break in an Insured's coverage.

Takeover Benefits may prevent you from having a lapse in dental insurance when your Employer replaces other group dental coverage with comparable benefits under this certificate. For Takeover Benefits to apply, you must be insured under the Prior Plan on the day before the effective date of this certificate.

Takeover is also available to new hires, those who enroll during open enrollment, or due to a Qualifying Life Event with prior-like group dental coverage, provided there has not been a lapse in coverage greater than 63 days. You are responsible for providing proof of your Prior Plan which should include, but not be limited to, coverage effective dates, a benefit summary, certificate of coverage, etc.

For purposes of this section, Prior Plan means your prior group dental insurance policy with your employer.

High Plan

Takeover Details *Benefit Waiting Period*

If Insureds qualify for Takeover Benefits, they will receive Benefit Waiting Period credit for Preventive, Basic, and Major Covered Procedures.

Deductible

Deductible credit will be equal to the amount of the Deductible satisfied under the Prior Plan during the current plan year upon receipt of proof that the expenses were incurred.

Maximum Benefit

Subject to receipt of proof, any benefits paid under the Prior Plan during the current plan year with respect to such replaced coverage will be applied to and deducted from the Maximum Benefit payable under this certificate.

Orthodontics Benefit Rider Maximum Benefit

If an Insured's coverage under this certificate includes the Orthodontics Benefit Rider, benefits will be paid for orthodontic treatment started while covered under the Prior Plan if:

- bands or appliances were inserted while insured under the Prior Plan;
- orthodontic treatment is continued while an Insured has coverage under this certificate; and
- we receive proof that an Insured's treatment while covered under the Prior Plan has not exceeded the Orthodontics Benefit Rider Maximum Benefit.

If you submit the required proof, the Orthodontics Maximum Benefit will be the lesser of the Orthodontics Maximum Benefit included in the Orthodontics Benefit Rider or the Prior Plan's orthodontic maximum benefit. The Orthodontic Maximum Benefit will be reduced by the amount paid or payable under the Prior Plan.

Low Plan

Takeover Details *Benefit Waiting Period*

If Insureds qualify for Takeover Benefits, they will receive Benefit Waiting Period credit for Preventive, Basic, and Major Covered Procedures.

Deductible

Deductible credit will be equal to the amount of the Deductible satisfied under the Prior Plan during the current plan year upon receipt of proof that the expenses were incurred.

Maximum Benefit

Subject to receipt of proof, any benefits paid under the Prior Plan during the current plan year with respect to such replaced coverage will be applied to and deducted from the Maximum Benefit payable under this certificate.

Prior Carrier's Responsibility

The prior carrier is responsible for costs for procedures begun prior to the Policy Effective Date.

Coverage for Treatment in Progress

We may cover dental expenses for treatment already in progress on the Policy Effective Date provided the dental expenses are covered under this certificate and the Prior Plan.

Extension of Benefits under Prior Plan

We will not pay benefits for treatment if:

- the Prior Plan has an extension of benefits provision;
- the treatment expenses were incurred under the Prior Plan; and
- the treatment was completed during the extension of benefits.

No Extension of Benefits under Prior Plan

We will pro-rate benefits according to the percentage of treatment performed while insured under the Prior Plan if:

- the Prior Plan has no extension of benefits when that plan terminates;
- the treatment expenses were incurred under the Prior Plan; and
- the treatment was completed while insured under this certificate.

Treatment Not Completed during Extension of Benefits

We will pro-rate benefits according to the percentage of treatment performed while insured under the Prior Plan and during the extension if:

- the Prior Plan has an extension of benefits;
- the treatment expenses were incurred under the Prior Plan; and
- the treatment was not completed during the Prior Plan's extension of benefits.

Only the percentage of treatment completed beyond the extension period will be considered when determining if any benefits are paid under this certificate.

Eligibility Waiting Period	<p>The Eligibility Waiting Period is the continuous period of time you must be in an Eligible Group before you are eligible to enroll for coverage.</p> <p>Immediately following the first day of Active Employment.</p>
Enrolling for Coverage	<p>You may enroll for coverage:</p> <ul style="list-style-type: none">- within 31 days from the date an Insured is eligible;- within 31 days from the date of a Qualifying Life Event; or- during the annual Enrollment Period. <p>You must be enrolling in coverage for yourself or have existing coverage under this certificate in order to apply for coverage for your Spouse or Children.</p> <p>Your newborn or newly adopted Children will automatically be covered for 31 days from the date the Child becomes eligible, provided you are insured. If you wish to continue Child coverage, you must notify us on or before the end of the 31 day period and pay any additional premium.</p>
Coverage Effective Date	<p>Coverage for an Insured will begin on the date the Insured is eligible for coverage.</p>
Coverage Effective Date for Changes in Coverage	<p>Changes to an Insured's coverage will begin:</p> <ul style="list-style-type: none">- the date determined by the Enrollment Period; or- the date you apply for a change in coverage due to a Qualifying Life Event, if you apply within 31 days of the Qualifying Life Event. <p>A cancellation in coverage will take effect:</p> <ul style="list-style-type: none">- the date the cancellation in coverage is made;- the first day of the pay period in which deductions are taken; or- the date agreed upon by us and your Employer. <p>Any change or cancellation in coverage will not affect a Payable Claim which occurs prior to the change or cancellation.</p>
Coverage Effective Date if you are not in Active Employment	<p>You must be in Active Employment in order for coverage to become effective.</p> <p>If you are not in Active Employment due to an Injury, Sickness, or Leave of Absence on the date coverage would become effective, coverage will begin on the date you return to Active Employment.</p> <p>The Coverage Effective Date and Coverage Effective Date for Changes in Coverage provisions are subject to this provision.</p>

**Continuation of
your Coverage
During Extended
Absences***Leave of Absence, other than a Family and Medical Leave of Absence or Leave of Absence due to Military Service*

You will be covered for 1 year from the date your absence begins, provided premium is paid.

Family and Medical Leave of Absence

We will continue coverage in accordance with your Employer's Human Resource policy on family and medical leaves of absence provided premium payments continue and your Employer approved your leave in Writing. You will be covered up to the end of the latest of:

- the leave period required by the Federal Family and Medical Leave Act of 1993, and any amendments;
- the leave period required by applicable state law; or
- the leave period provided to you for an Injury or Sickness, provided premium is paid and your Employer has approved your leave in Writing.

If your Employer's Human Resource policy doesn't provide for continuation of your coverage during a Family and Medical Leave of Absence, coverage will be reinstated when you return to Active Employment.

We will not apply a new Eligibility Waiting Period.

Leave of Absence due to Military Service

You will be covered for 1 year from the date your absence begins, provided premium is paid.

If you have not returned to work after the allotted time for continuation of coverage, your coverage will be suspended and reinstated in accordance with the requirements of the federal Uniformed Services Employment and Reemployment Rights Act (USERRA).

Injury or Sickness

You will be covered for up to 1 year from the date your absence begins due to an Injury or Sickness, provided premium is paid.

End of Coverage*For You*

You may cancel your coverage during an Enrollment Period or during a Qualifying Life Event. Your coverage will end the first of the month coincident with or next following the date you provide notification to your Employer.

Otherwise, your coverage under this certificate ends on the first of the month following the earliest of:

- the date the policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage During Extended Absences provision.

We will provide coverage for a Payable Claim that occurs while you are covered under this certificate. In no event will a Covered Procedure started after an Insured's coverage ends be payable.

For your Spouse

If, while your coverage is in force, you choose to cancel your Spouse's coverage under this certificate, your Spouse's coverage will end the first of the month coincident with or next following the date you provide notification to your Employer.

Otherwise, your Spouse's coverage will end on the first of the month following the

End of Coverage

earliest of:

- the date your coverage under this certificate ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or
- the date of divorce or annulment.

We will provide coverage for a Payable Claim that occurs while your Spouse is covered under this certificate.

For your Children

If, while your coverage is in force, you choose to cancel your Children's coverage under this certificate, your Children's coverage will end the first of the month coincident with or next following the date you provide notification to your Employer.

Otherwise, your Children's coverage will end on the first of the month following the earliest of:

- the date your coverage under this certificate ends;
- the date your Children are no longer eligible for coverage;
- the date of your Child's death; or
- the date your Children no longer meet the definition of Children.

We will provide coverage for a Payable Claim that occurs while your Children are covered under this certificate.

Filing a Claim

We encourage notification of a claim for benefits under this certificate so that a claim decision can be made in a timely manner. If there are any questions on how to file a claim, please contact us or your Employer.

Step 1 - Claim Forms

Most Providers file claims electronically or have claim forms on hand. Claim forms are also available on our website www.Unumdentalcare.com or by contacting us directly at (888) 400-9304. We will provide a claim form within 15 days of your request.

If you or your authorized representative do not receive a claim form from us within 15 days after we receive notice of a claim, a Written statement that includes a description of services, billed charges, and any additional documentation you received from your Provider will be deemed Proof of Loss, if sent to us within the time limit stated in the Proof of Loss section below.

Completed claim forms may be sent to us by mail, e-mail, or fax:

Mailing Address Claims Department
P.O. Box 80139
Baton Rouge, LA 70898-0139

Fax (855) 400-9307

E-mail DentalClaims@Unum.com

Step 2 - Proof of Loss

Proof of Loss must be sent to us no later than 90 days after the date of service. The Insured's receipt of charges for services rendered by a Provider is Proof of Loss. If it is not reasonably possible to provide Proof of Loss within this time period, it must be provided within one year, unless the Insured lacks the legal capacity to do so.

The receipt of charges submitted to us for proof must include the treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and nomenclature, or a narrative description. X-rays, narratives, and other diagnostic information may be required to determine benefits.

We will request additional information if Proof of Loss is not complete.

Services Performed Outside the United States of America

Claims submitted for any dental treatment performed outside the United States must:

- be supplied in English;
- use American Dental Association (ADA) codes; and
- be in U.S. Dollar currency.

Claim Procedures

After the Insured has satisfied the requirements under Filing a Claim, we will process and evaluate the information to determine if a claim is payable. We will notify the Insured of a claim decision within 30 days. Benefits will be paid in accordance with the Payment of Benefits provision.

If we determine additional time is needed to review a claim, we may extend this time period by 30 days. We will notify the Insured of the circumstances requiring a review extension and when we anticipate making a claim decision.

If a claim for benefits under this certificate is wholly or partially denied, we will provide notice of our decision in Writing. The notice of denial will state the specific reason for the denial of benefits.

Payment of Benefits

Benefits for which we are liable will be paid after we complete the Claims Procedures. All benefits will be paid to you, unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits.

Claim Provisions

If there are legal impediments to Payment of Benefits under this certificate which depend on the actions of parties other than us, we may hold further benefits due until such impediments are resolved and sufficient Proof of Loss of the same is provided to us.

In the event of your death, any unpaid benefits will be paid to your estate. If benefits are payable to your estate, we can pay benefits up to \$1,000 to someone related to you by blood or marriage whom we consider entitled to the benefits. Any payment made by us in good faith pursuant to this provision will fully release us to the extent of such payment.

Payment to a Minor or Incompetent Insured

If an Insured is a minor or is incompetent, we can pay up to \$1,000 to the person or institution that appears to have assumed the custody and main support of the Insured or the minor unless or until that Insured, or minor's appointed legal representative makes a formal claim. If we pay benefits to such person or institution, we will not have to pay those benefits again.

Overpayment of Claims

We have the right to recover any overpayments from Insureds and Providers due to:

- fraud;
- Misstatement of Information; or
- any error we make in processing a claim.

We must be reimbursed in full. If it is not possible to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments.

We will not recover more money than the amount we paid.

Underpayment of Claims

We have the responsibility to make additional payments if any underpayments have been made. Any underpayments will be paid in accordance with the Payment of Benefits provision.

Complaint and Appeal Procedures

Complaints

You shall report any complaints to us at (888) 400-9304. Complaints may be submitted to us verbally or in Writing. You may submit Written comments or supporting documentation concerning your complaint to assist in our review. We will address the complaint within 30 days after receipt or, unless special circumstances require an extension of time. In that case, resolution will be achieved as soon as possible, but not later than 120 days after our receipt of the complaint.

Claim Denial

If we deny all or any part of your claim, you can access the claim status detail on www.UnumDentalcare.com, you have the right to receive a Written notice of denial setting forth:

- the specific reasons for the denial;
- the specific policy provisions on which the denial is based; and
- a description of the appeal procedures and time limits.

Upon receipt of a claim denial you have the right, upon request and free of charge, to receive:

- copies of all documents, records, and other information relevant to your claim for benefits; and
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary.

Appeal

If, under the terms of the policy, a claim is denied in whole or in part, a request may be submitted to us by you, or by your authorized representative, for a full review of the denial. You may designate any person, including your Provider, as your authorized representative. References in this section to "you" include your authorized representative, where applicable.

The request must be made within 60 days following your receipt of adverse benefit

Claim Provisions

determination and should contain sufficient information to identify the person for whom the claim was submitted, including:

- your or your Spouse's or Children's name;
- your or your Spouse's or Children's identification number and date of birth;
- the Provider of services; and
- the claim number.

An Insured may request, free of charge, any documents held by us regarding the denial of your claim. You or your Spouse or Children may also submit Written comments or supporting documentation concerning the claim to assist in our review.

Our response to your request for review, including specific reasons for the decision and reference to the specific plan provision on which the benefit determination is based, shall be provided and communicated to you or your Spouse or Children no later than 60 days after receipt of a request for an appeal from you or your Spouse or Children, unless, due to special circumstances, we need an extension of time to process your appeal. In the event that we do request an extension of time, notice will be provided to you prior to the expiration of the initial 60 day period, and the extension will not exceed a period of 60 days from the end of the initial 60 day time period.

Copies of all appeals and responses are available for inspection by the state insurance department or equivalent authority.

ERISA

If your Plan is governed by ERISA, claim denial and appeal procedures as well as your right to lawsuit should comply with ERISA requirements, which might be different from the state requirements stated above.

Additionally, under the provisions of ERISA (Section 502(a)) 29 U.S.C. 1132(a), you may have the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole, and you disagree with the outcome.

Other Remedies

When you have completed the appeals process described above, additional voluntary alternative dispute resolution options may be available, including mediation. One way to find out what may be available is to contact the U.S. Department of Labor and your State insurance regulatory agency.

Legal Actions

You or your authorized representative may initiate Legal Action on a claim if you or your authorized representative disagree with our decision. The time limit on Legal Actions is subject to applicable law in the state where the policy is issued. Unless stated otherwise under federal law, Legal Action may begin 60 days from the date Proof of Loss is required and up to two years from the date of the loss.

When Days Begin and End	For the purpose of all dates under this certificate, all days begin at 12:01 a.m. and end at 12:00 midnight.
Certificate of Coverage	<p>We will provide the Policyholder with a certificate for distribution to each insured Employee. The certificate describes:</p> <ul style="list-style-type: none"> - the coverage to which an Insured may be entitled; - to whom we will make a payment; and - the limitations, exclusions, and requirements that apply to an Insured's coverage. <p>If the provisions of this certificate are different from the provisions of the policy, the provisions of the policy will govern.</p>
Certificate of Coverage Contents	<p>Coverage for an Insured is provided under the provisions of this certificate. The provisions of this certificate are made part of the policy issued to the Policyholder.</p> <p>The policy consists of all provisions of the policy, the provisions of this certificate, the Policyholder's application, and all related schedules, riders, amendments, and endorsements.</p>
Cancellation or Modification to the Policy and this Certificate of Coverage	<p>The policy and this certificate may be cancelled or modified by the Employer at any time without the Insured's consent. Any cancellation or modification to the policy or certificate requested by the Employer will take effect on the date agreed upon by us and the Employer.</p> <p>All policy and certificate modifications will take effect according to the provisions in the Start of Coverage section of this certificate.</p>
Assignment	<p>An Assignment transfers all or part of your legal title and rights under the policy and this certificate to someone else, known as an "assignee." We will recognize your assignee(s) as owners of the rights you transferred under the policy and this certificate if:</p> <ul style="list-style-type: none"> - the Written form has been signed by you and the assignee and the form is acceptable to us; and - a signed or certified copy of the Written Assignment has been filed with us. <p>An Assignment will take effect on the date notice of the Assignment is signed by you. If we have taken any action or made any payment before we receive notice of the Assignment, that Assignment will not go into effect for those actions taken or payments made. Unless stated otherwise in or allowed by the Assignment, the Assignment does not change an Insured's coverage.</p> <p>We are not responsible for the validity of any Assignment. We advise you to verify your Assignment is legal in your state and that it accomplishes the goals you intend.</p>
Contestability	We can take legal or other action using statements made in signed applications for coverage only when a claim occurs during the first two years after an Insured's Coverage Effective Date. However, in the event of Fraud, we can take legal or other action at any time as permitted by applicable law.
Misstatement of Information	<p>If we receive information about an Insured that is incorrect, we will:</p> <ul style="list-style-type: none"> - review the information to decide whether the Insured has coverage and in what amounts; and - if necessary, make the applicable premium adjustments.
Fraud	<p>We want to make sure you and your Employer do not incur additional insurance costs as the result of the undermining effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.</p> <p>It is a crime if anyone knowingly, and with intent to injure, defrauds, or deceives us. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.</p>

General Provisions

These actions will result in denial of a claim and are subject to prosecution and punishment to the full extent under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

Agency

For purposes of the policy, your Employer acts on their own behalf or as your agent. Under no circumstances will your Employer be deemed our agent.

Communicating with you or your Employer

To protect our customers, when communicating with others in Writing, we will abide by all applicable privacy laws and regulations.

Active Employment	<p>You are working for your Employer for earnings that are paid regularly and you are performing the usual and customary duties of your job. You must be regularly scheduled to work at least the minimum number of hours defined by your Eligible Group.</p> <p>Your work site must be:</p> <ul style="list-style-type: none"> - your Employer's usual place of business in the United States; - an alternative work site in the United States at the direction of your Employer; or - a location in the United States to which your job requires you to travel. <p>Normal vacation, holidays, or temporary business closures are considered Active Employment provided you are in Active Employment on the last scheduled work day preceding such time off.</p> <p>For purposes of this Certificate, temporary business closures that meet the Glossary definition of Active Employment include, but are not limited to:</p> <ul style="list-style-type: none"> - inclement weather; - power outage; and - public health agency orders. <p>Temporary and seasonal workers are excluded from coverage.</p>
Calendar Year	<p>The period beginning on the Insured's Coverage Effective Date and ending on December 31 of the same year. For each following year, it is the period beginning on January 1 and ending on December 31.</p>
Children	<p>Any child from live birth to the end of the year in which they reach age 26 who is:</p> <ul style="list-style-type: none"> - your own natural offspring; - your Spouse's child; - your lawfully adopted child as of the earliest of the date: <ul style="list-style-type: none"> - the child is placed in your home or in a medical facility; - a petition is filed for you to adopt the child; or - an adoption agreement signed by you that includes your binding obligation to assume financial responsibility for the child; - a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction; - grandchildren, nieces, and nephews living with you in a regular parent child relationship that are dependent on you for primary financial support; or - any other child residing with you through legal mandate that is dependent on you for financial support. <p>Coverage for your Child may be continued past the end of the year in which they reach age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.</p> <p>You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.</p> <p>Your Children may not be Insured as both a Child and an Employee.</p> <p>Your Children may not be Insured by more than one Employee.</p>
Contributory Coverage	<p>Any amount of coverage for which you pay all or part of the premium. The maximum amount that you may be required to contribute to the cost of your coverage shall not exceed the premium charged for the amount of your coverage.</p>
Covered Procedure	<p>The procedures listed in the Schedule of Covered Procedures. Benefits will only be paid for services identified in the Schedule of Covered Procedures.</p>

Employee	A person, also referred to as "you," who is in Active Employment.
Employer	The Policyholder, including all United States divisions, subsidiaries, and affiliated companies of the named Policyholder for whose Employees premium is being paid.
Enrollment Period	A period of time determined by your Employer and us during which you are eligible to enroll for or change your coverage. This period of time may be limited.
Injury	Any damage or harm to the body that is the direct result of an accident and not related to any other cause. Injuries that occur prior to an Insured's Coverage Effective Date will be treated as any other Sickness.
Insured	Any person who has coverage under the policy.
Leave of Absence	<p>Temporary absence from Active Employment for a period of time under a leave granted in Writing by your Employer that is in accordance with your Employer's formal leave policies.</p> <p>Normal vacation time, holidays, or temporary business closure is not considered a Leave of Absence.</p>
Payable Claim	A claim for which we are liable under the provisions of the policy.
Policyholder	The entity to which the policy is issued.
Policy Year	January 1, 2025 to January 1, 2026 and each following January 1 to January 1.
Provider	<p>A dentist, dental hygiene therapist, independent practice dental hygiene therapist, or any dental professional that is:</p> <ul style="list-style-type: none"> - properly licensed or certified under the laws of the state where they practice; and - perform tasks that are within the limits of their license. <p>We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Provider for a claim that you send to us.</p> <p><i>In-Network Provider</i> A Provider who has agreed to accept a negotiated fee for Covered Procedures agreed to by us and the Provider. A listing of In-Network participating Providers is available online at www.Unumdentalcare.com or by contacting us directly at (888) 400-9304.</p> <p><i>Out-of-Network Provider</i> A Provider who has not entered into an agreement with us to limit charges for any procedures.</p>
Qualifying Life Event	<p>For coverage eligibility purposes, a Qualifying Life Event includes, but is not limited to:</p> <ul style="list-style-type: none"> - birth, adoption, or addition of a Child; - a change in legal marital status; - a change in employment status; or - death of an Insured. <p>Changes in coverage made as a result of a Qualifying Life Event must be consistent with the Qualifying Life Event.</p> <p>For further information regarding Qualifying Life Events, please refer to your Employer's human resource policy.</p>
Sickness	An illness or disease.
Spouse	The person who is your partner through lawful marriage, civil union, domestic partnership (established by a declaration acceptable to us), or your legally separated Spouse.

**Starmount Life
Insurance
Company**

**Writing or
Written**

Your Spouse may not be Insured as both a Spouse and an Employee.

Referred to as "Starmount" and "we," "us," or "our."

A record on or transmitted by paper, electronic, or telephonic media consistent with applicable law.



Group Dental Insurance Schedule of Covered Procedures

The following Schedule of Covered Procedures describes each procedure for which benefits are payable. All claims for Covered Procedures are subject to review. In addition, Covered Procedures are subject to the applicable Frequencies and Limitations. Procedure Frequencies are determined on a rolling basis, beginning on the date of service for that Covered Procedure.

Diagnostic		
Procedure Class	Covered Procedure Description	ADA Code
Preventive	Periodic oral evaluation - established patient	D0120
	Oral evaluation for a patient under three years of age and counseling with primary caregiver	D0145
	Frequency	
	Limited to any 2 of these procedure codes per 12 months. D0150 is included in this limitation.	
	Limitation	
Preventive	Comprehensive oral evaluation - new or established patient	D0150
	Frequency	
	Limited to any 2 of these procedure codes per 12 months per provider. D0120 and D0145 are included in this limitation.	
	Limitation	
Preventive	Comprehensive periodontal evaluation - new or established patient	D0180
	Frequency	
	Maximum of 1 procedure per 12 months.	
Preventive	Limited oral evaluation - problem focused	D0140
	Detailed and extensive oral evaluation - problem focused, by report	D0160
	Re-Evaluation - limited, problem focused (established patient; not post-operative visit)	D0170
	Frequency	
	Limited to any 1 of these procedure codes per 12 months.	
	Limitation	
Preventive	An alternate benefit may be provided.	
	Intraoral - complete series of radiographic images	D0210
	Frequency	
	Limited to any 1 of D0210 or D0330 per 36 months.	
Preventive	Limitation	
	Intraoral - periapical first radiographic image	D0220
	Intraoral - periapical each additional radiographic image	D0230
	Frequency	
	Maximum of 7 images combined D0220 and D0230 per visit.	
Preventive	Limitation	
	If 8 or more images in combination of D0220, D0230, D0270, D0272, D0273, D0274, D0277 or any image done with a D0330 are taken during a single visit an alternate benefit of D0210 will be given.	
	Intraoral - occlusal radiographic image	D0240
	Frequency	
Preventive	Maximum of 2 procedure per 12 months.	
	Limitation	

Preventive	Bitewing - single radiographic image	D0270
	Bitewings - two radiographic images	D0272
	Bitewings - three radiographic images	D0273
	Bitewings - four radiographic images	D0274
	Frequency	
	Limited to any 1 of these procedure codes per 12 months up to 4 radiograph images per visit.	
	Limitation	
	If 8 or more images in combination of D0220, D0230, D0270, D0272, D0273, D0274, D0277 or any image done with a D0330 are taken during a single visit an alternate benefit of D0210 will be given.	
Preventive	Vertical bitewings - 7 to 8 radiographic images	D0277
	Frequency	
	Maximum of 1 procedure per 12 months in combination with D0270, D0272, D0273, and D0274.	
	Limitation	
	An alternate benefit may be provided.	
Preventive	Panoramic radiographic image	D0330
	Frequency	
	Limited to any 1 of D0210 or D0330 per 36 months.	
	Limitation	
	If 8 or more images in combination of D0220, D0230, D0270, D0272, D0273, D0274, D0277 or any image done with a D0330 are taken during a single visit an alternate benefit of D0210 will be given.	
Major	2D oral/facial photographic image obtained intra-orally or extra-orally	D0350
	Frequency	
	Maximum of 1 procedure per lifetime.	
	Limitation	
Preventive	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	
	D0431	
	Frequency	
	Maximum of 1 procedure per 12 months.	
	Limitation	
	Procedure is limited to Insureds age 40 and older.	
	Procedure is only covered when there is presence of suspicious lesions or for those who demonstrate risk factors for oral cancer.	

Preventive		
Procedure Class	Covered Procedure Description	ADA Code
Preventive	Prophylaxis - adult	D1110
	Prophylaxis - child	D1120
	Frequency	
	Limited to 2 procedures per 12 months in combination of D1110, D1120 and D4910.	
	Limitation	
	One additional prophylaxis or periodontal maintenance per year if Member is in second or third trimester of pregnancy. Written verification of pregnancy and due date from patient's physician and claim narrative from dentist must be submitted at time of claim.	
Preventive	Topical application of fluoride varnish	D1206
	Topical application of fluoride - excluding varnish	D1208
	Frequency	
	Limited to any 1 of these procedure codes per 12 months.	
	Limitation	
	Procedure is limited to Insureds under the age of 16.	
Preventive	Sealant - per tooth	D1351
	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	D1352
	Frequency	
	Limited to any 1 of these procedure codes per tooth, per 36 months.	
	Procedure covered only for permanent molar teeth which have no prior occlusal restoration.	
	Limitation	
	Procedure is limited to Insureds under the age of 16.	
	Alternate benefit may be given for D1352.	

Preventive	Space maintainer - fixed, unilateral - per quadrant	D1510
	Space maintainer - fixed - bilateral, maxillary	D1516
	Space maintainer - fixed - bilateral, mandibular	D1517
	Space maintainer - removable, unilateral - per quadrant	D1520
	Space maintainer - removable - bilateral, maxillary	D1526
	Space maintainer - removable - bilateral, mandibular	D1527
	Distal shoe space maintainer - fixed, unilateral - per quadrant	D1575
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	Limitation	
	Procedure covered only when used to hold space for permanent tooth after the loss of primary tooth.	

Restorative		
Procedure Class	Covered Procedure Description	ADA Code
Basic	Amalgam - one surface, primary or permanent	D2140
	Amalgam - two surfaces, primary or permanent	D2150
	Amalgam - three surfaces, primary or permanent	D2160
	Amalgam - four or more surfaces, primary or permanent	D2161
	Frequency	
	Limited to any 1 restoration (filling/reattachment) by tooth surface per 24 months.	
	Limitation	
Basic	Resin-Based composite - one surface, anterior	D2330
	Resin-Based composite - two surfaces, anterior	D2331
	Resin-Based composite - three surfaces, anterior	D2332
	Resin-Based composite - four or more surfaces or involving incisal angle (anterior)	D2335
	Frequency	
	Limited to any 1 restoration (filling/reattachment) by tooth surface per tooth per 24 months.	
	Limitation	
Major	Resin-Based composite crown, anterior	D2390
	Frequency	
	Maximum of 1 procedure per 5 years.	
	Limitation	
Basic	Resin-Based composite - one surface, posterior	D2391
	Resin-Based composite - two surfaces, posterior	D2392
	Resin-Based composite - three surfaces, posterior	D2393
	Resin-Based composite - four or more surfaces, posterior	D2394
	Frequency	
	Limited to any 1 restoration (filling/reattachment) by tooth surface per tooth per 24 months.	
	Limitation	
Basic	Gold foil - one surface	D2410
	Gold foil - two surfaces	D2420
	Gold foil - three surfaces	D2430
	Frequency	
	Limited to any 1 restoration (filling/reattachment) by tooth surface per tooth per 24 months.	
	Limitation	
	Benefits may be based on the corresponding non-cosmetic restoration.	
Major	Inlay - metallic - one surface	D2510
	Inlay - metallic - two surfaces	D2520
	Inlay - metallic - three or more surfaces	D2530
	Inlay - porcelain/ceramic - one surface	D2610
	Inlay - porcelain/ceramic - two surfaces	D2620
	Inlay - porcelain/ceramic - three or more surfaces	D2630
	Inlay - resin-based composite - one surface	D2650
	Inlay - resin-based composite - two surfaces	D2651
	Inlay - resin-based composite - three or more surfaces	D2652
	Frequency	

	Limited to 1 of these restorations including inlay, onlay, or any type of crown, per tooth per 5 years.	
	Limitation	
Major	Onlay - metallic - two surfaces	D2542
	Onlay - metallic - three surfaces	D2543
	Onlay - metallic - four or more surfaces	D2544
	Onlay - porcelain/ceramic - two surfaces	D2642
	Onlay - porcelain/ceramic - three surfaces	D2643
	Onlay - porcelain/ceramic - four or more surfaces	D2644
	Onlay - resin-based composite - two surfaces	D2662
	Onlay - resin-based composite - three surfaces	D2663
	Onlay - resin-based composite - four or more surfaces	D2664
	Frequency	
	Limited to 1 of these restorations including inlay, onlay, or any type of crown, per tooth per 5 years.	
	Limitation	
Major	Crown - resin with high noble metal	D2720
	Crown - resin with predominantly base metal	D2721
	Crown - resin with noble metal	D2722
	Crown - porcelain/ceramic	D2740
	Crown - porcelain fused to high noble metal	D2750
	Crown - porcelain fused to predominantly base metal	D2751
	Crown - porcelain fused to noble metal	D2752
	Crown - porcelain fused to titanium and titanium alloys	D2753
	Crown - 3/4 cast high noble metal	D2780
	Crown - 3/4 cast predominantly base metal	D2781
	Crown - 3/4 cast noble metal	D2782
	Crown - 3/4 porcelain/ceramic	D2783
	Crown - full cast high noble metal	D2790
	Crown - full cast predominantly base metal	D2791
	Crown - full cast noble metal	D2792
	Crown - titanium and titanium alloys	D2794
	Frequency	
	Limited to 1 of these restorations including inlay, onlay, or any type of crown, per tooth per 5 years.	
	Limitation	
Basic	Re-Cement or re-bond inlay, onlay, veneer or partial coverage restoration	D2910
	Re-Cement or re-bond crown	D2920
	Frequency	
	Maximum of 1 procedure per tooth, per 12 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	
Basic	Prefabricated stainless steel crown - primary tooth	D2930
	Prefabricated stainless steel crown - permanent tooth	D2931
	Prefabricated resin crown	D2932
	Prefabricated stainless steel crown with resin window	D2933
	Prefabricated esthetic coated stainless steel crown - primary tooth	D2934
	Frequency	
	Limited to any 1 of these restorations including inlay, onlay, or any type of crown, per tooth per 5 years.	
	Limitation	
Major	Protective restoration	D2940
	Frequency	
	Maximum of 1 procedure per tooth per 24 months.	
	Limitation	
Major	Core buildup, including any pins when required	D2950
	Frequency	
	Maximum of 1 procedure per tooth, per 5 years.	

	Limitation	
Major	Post and core in addition to crown, indirectly fabricated	D2952
	Prefabricated post and core in addition to crown	D2954
	Frequency	
	Limited to any 1 of these procedure codes per tooth, per 5 years.	
	Limitation	
Major	Labial veneer (resin laminate) - chairside	D2960
	Labial veneer (resin laminate) - laboratory	D2961
	Labial veneer (porcelain laminate) - laboratory	D2962
	Frequency	
	Limited to 1 of these restorations including any type of crown, per tooth per 5 years.	
Basic	Crown repair necessitated by restorative material failure	D2980
	Veneer repair necessitated by restorative material failure	D2983
	Frequency	
	Maximum of 1 procedure each per tooth per 12 months.	
	6 months must have passed since initial placement/treatment.	
Basic	Inlay repair necessitated by restorative material failure	D2981
	Frequency	
	Maximum of 1 procedure each per tooth per 12 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	
Basic	Onlay repair necessitated by restorative material failure	D2982
	Frequency	
	Maximum of 1 procedure each per tooth per 12 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	

Endodontics		
Procedure Class	Covered Procedure Description	ADA Code
Basic	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	D3220
	Frequency	
	Limited to any 1 of these procedures per tooth, per lifetime.	
	Limitation	
Basic	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	D3230
	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	D3240
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	Limitation	
Basic	Endodontic therapy, anterior tooth (excluding final restoration)	D3310
	Endodontic therapy, premolar tooth (excluding final restoration)	D3320
	Endodontic therapy, molar tooth (excluding final restoration)	D3330
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	Limitation	

Basic	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	D3332
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	Limitation	
Basic	Retreatment of previous root canal therapy - anterior	D3346
	Retreatment of previous root canal therapy - premolar	D3347
	Retreatment of previous root canal therapy - molar	D3348
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	6 months must have passed since initial placement/treatment.	
	Limitation	
Basic	Apicoectomy - anterior	D3410
	Apicoectomy - premolar (first root)	D3421
	Apicoectomy - molar (first root)	D3425
	Apicoectomy (each additional root)	D3426
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	Limitation	
Basic	Retrograde filling - per root	D3430
	Frequency	
	Maximum of 1 procedure per tooth root, per lifetime.	
	Limitation	
Basic	Root amputation - per root	D3450
	Frequency	
	Maximum of 1 procedure per tooth root, per lifetime.	
	Limitation	

Periodontics		
Procedure Class	Covered Procedure Description	ADA Code
Basic	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	D4210
	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	D4211
	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	D4240
	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	D4241
	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	D4260
	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	D4261
	Pedicle soft tissue graft procedure	D4270
	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	D4273
	Non-Autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	D4275
	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	D4277
	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	D4278
	Frequency	
	Limited to any 1 of these procedure codes per quadrant, per 24 months.	
	Limitation	
Basic	Clinical crown lengthening - hard tissue	D4249

	Frequency	
	Maximum of 1 procedure per tooth, per 60 months.	
	Limitation	
Basic	Periodontal scaling and root planing - four or more teeth per quadrant	D4341
	Periodontal scaling and root planing - one to three teeth per quadrant	D4342
	Frequency	
	Maximum of 1 procedure per quadrant, per 24 months.	
	Limitation	
Basic	Procedures will not be covered if performed on the same day as comprehensive exams, prophylaxis, periodontal maintenance, or debridement.	
	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	D4346
	Frequency	
	Maximum of 1 procedure per quadrant, per 24 months.	
	Limitation	
Basic	Procedures will not be covered if performed on the same day as comprehensive exams, prophylaxis, periodontal maintenance, scaling/root planing, or debridement.	
	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	D4355
	Frequency	
	Maximum of 1 procedure per lifetime	
	Limitation	
Basic	Procedures will not be covered if performed on the same day as comprehensive exams, prophylaxis, periodontal maintenance, scaling/root planing, or debridement.	
	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	D4381
	Frequency	
	Maximum of 1 procedure per quadrant, per 12 months.	
	Limitation	
Basic	Periodontal maintenance	
	D4910	
	Frequency	
	Limited to 2 procedures per 12 months in combination with D1110 and D1120.	
	Limitation	
	Procedure is limited to Insureds age 16 and older.	
	One additional prophylaxis or periodontal maintenance per year if Member is in second or third trimester of pregnancy. Written verification of pregnancy and due date from patient's physician and claim narrative from dentist must be submitted at time of claim.	

Oral & Maxillofacial		
Procedure Class	Covered Procedure Description	ADA Code
Basic	Extraction, coronal remnants - primary tooth	D7111
	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	D7140
	Frequency	
	Maximum of 1 procedure per tooth.	
	Limitation	
Basic	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210
	Removal of impacted tooth - soft tissue	D7220
	Removal of impacted tooth - partially bony	D7230
	Removal of impacted tooth - completely bony	D7240
	Removal of residual tooth roots (cutting procedure)	D7250
	Frequency	
	Maximum of 1 procedure per tooth.	
	Limitation	
Basic	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7310

	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311
	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320
	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7321
	Frequency	
	Limited to any 1 of these procedure codes per quadrant, per 24 months.	
	Limitation	
Basic	Incision and drainage of abscess - intraoral soft tissue	D7510
	Frequency	
	Limitation	

Prosthodontics (removeable)		
Procedure Class	Covered Procedure Description	ADA Code
Major	Complete denture - maxillary	D5110
	Complete denture - mandibular	D5120
	Immediate denture - maxillary	D5130
	Immediate denture - mandibular	D5140
	Frequency	
	Limited to 1 procedure per arch, per 5 years including overdenture, implant/abutment supported denture.	
Major	Limitation	
	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	D5211
	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	D5212
	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	D5213
	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	D5214
	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	D5221
	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	D5222
	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	D5223
	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	D5224
	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	D5225
	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	D5226
	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	D5282
	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	D5283
	Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	D5284
	Removable unilateral partial denture - one piece resin (including clasps and teeth) - per quadrant	D5286
	Frequency	
	Limited to 1 procedure per arch per 5 years including replacement of teeth and acrylic on frameworks, partial overdentures, partial dentures, implants, mini-implants, implant /abutment supported partial dentures.	
	Limitation	
	An alternate benefit may be provided.	
Basic	Adjust complete denture - maxillary	D5410
	Adjust complete denture - mandibular	D5411
	Adjust partial denture - maxillary	D5421

	Adjust partial denture - mandibular	D5422
	Frequency	
	Maximum of 1 procedure per arch per 6 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	
Basic	Repair broken complete denture base, mandibular	D5511
	Repair broken complete denture base, maxillary	D5512
	Replace missing or broken teeth - complete denture (each tooth)	D5520
	Repair resin partial denture base, mandibular	D5611
	Repair resin partial denture base, maxillary	D5612
	Repair cast partial framework, mandibular	D5621
	Repair cast partial framework, maxillary	D5622
	Repair or replace broken retentive clasping materials - per tooth	D5630
	Replace broken teeth - per tooth	D5640
	Add tooth to existing partial denture	D5650
	Add clasp to existing partial denture - per tooth	D5660
	Frequency	
	Maximum of 1 procedure per tooth, per 12 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	
Basic	Rebase complete maxillary denture	D5710
	Rebase complete mandibular denture	D5711
	Rebase maxillary partial denture	D5720
	Rebase mandibular partial denture	D5721
	Frequency	
	Maximum of 1 procedure each per 24 months.	
	6 months must have passed since initial placement/treatment.	
Basic	Limitation	
	Reline complete maxillary denture (chairside)	D5730
	Reline complete mandibular denture (chairside)	D5731
	Reline maxillary partial denture (chairside)	D5740
	Reline mandibular partial denture (chairside)	D5741
	Reline complete maxillary denture (laboratory)	D5750
	Reline complete mandibular denture (laboratory)	D5751
	Reline maxillary partial denture (laboratory)	D5760
	Reline mandibular partial denture (laboratory)	D5761
	Frequency	
	Limited to any 1 of these procedure codes per arch, per 24 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	
Basic	Tissue conditioning, maxillary	D5850
	Tissue conditioning, mandibular	D5851
	Frequency	
	Maximum of 1 procedure per 12 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	

Prosthodontics (fixed)		
Procedure Class	Covered Procedure Description	ADA Code
Major	Pontic - indirect resin based composite	D6205
	Pontic - cast high noble metal	D6210

	Pontic - cast predominantly base metal	D6211
	Pontic - cast noble metal	D6212
	Pontic - titanium and titanium alloys	D6214
	Pontic - porcelain fused to high noble metal	D6240
	Pontic - porcelain fused to predominantly base metal	D6241
	Pontic - porcelain fused to noble metal	D6242
	Pontic - porcelain fused to titanium and titanium alloys	D6243
	Pontic - porcelain/ceramic	D6245
	Pontic - resin with high noble metal	D6250
	Pontic - resin with predominantly base metal	D6251
	Pontic - resin with noble metal	D6252
	Frequency	
	Limited to any 1 of these procedure codes per 5 years including partial overdentures, partial dentures, implants, mini-implants, implant /abutment supported partial dentures, and bridges.	
	Limitation	
Major	Retainer - cast metal for resin bonded fixed prosthesis	D6545
	Retainer crown - porcelain/ceramic	D6740
	Retainer crown - porcelain fused to high noble metal	D6750
	Retainer crown - porcelain fused to predominantly base metal	D6751
	Retainer crown - porcelain fused to noble metal	D6752
	Retainer crown - 3/4 cast high noble metal	D6780
	Retainer crown - 3/4 cast predominantly base metal	D6781
	Retainer crown - full cast high noble metal	D6790
	Retainer crown - full cast predominantly base metal	D6791
	Frequency	
	Limited to any 1 of these procedure codes per 5 years including inlays, onlays, crowns, bridges and partial dentures.	
	Limitation	
Major	Retainer crown - indirect resin based composite	D6710
	Retainer crown - resin with high noble metal	D6720
	Retainer crown - resin with predominantly base metal	D6721
	Retainer crown - resin with noble metal	D6722
	Retainer crown - porcelain fused to titanium and titanium alloys	D6753
	Retainer crown - 3/4 cast noble metal	D6782
	Retainer crown - 3/4 porcelain/ceramic	D6783
	Retainer crown 3/4 - titanium and titanium alloys	D6784
	Retainer crown - full cast noble metal	D6792
	Retainer crown - titanium and titanium alloys	D6794
	Frequency	
	Limited to any 1 of these procedure codes per 5 years including inlays, onlays, crowns, bridges and partial dentures.	
	Limitation	
Basic	Re-Cement or re-bond fixed partial denture	D6930
	Fixed partial denture repair necessitated by restorative material failure	D6980
	Frequency	
	Maximum of 1 procedure each per 12 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	

Implant Services		
Procedure Class	Covered Procedure Description	ADA Code
Major	Surgical placement of implant body: endosteal implant	D6010
	Surgical placement of mini implant	D6013
	Surgical placement: eposteal implant	D6040
	Surgical placement: transosteal implant	D6050
	Frequency	

	Limited to any 1 procedure for implants, partial dentures, and bridges per tooth, per lifetime.	
	Limitation	
Major	Prefabricated abutment - includes modification and placement	D6056
	Custom fabricated abutment - includes placement	D6057
	Frequency	
	Maximum of 1 procedure per tooth, per 5 years.	
	Limitation	
	Only covered if an implant is covered.	
Major	Abutment supported porcelain/ceramic crown	D6058
	Abutment supported porcelain fused to metal crown (high noble metal)	D6059
	Abutment supported porcelain fused to metal crown (predominantly base metal)	D6060
	Abutment supported porcelain fused to metal crown (noble metal)	D6061
	Abutment supported cast metal crown (predominantly base metal)	D6063
	Implant supported porcelain/ceramic crown	D6065
	Implant supported crown - porcelain fused to high noble alloys	D6066
	Frequency	
	Limited to 1 replacement for implants, partial dentures, and bridges per tooth per 5 years.	
	Limitation	
	Benefits may be based on the corresponding non-cosmetic restoration.	
Major	Abutment supported cast metal crown (high noble metal)	D6062
	Abutment supported cast metal crown (noble metal)	D6064
	Implant supported crown - high noble alloys	D6067
	Implant supported crown - porcelain fused to predominantly base alloys	D6082
	Implant supported crown - porcelain fused to noble alloys	D6083
	Implant supported crown - porcelain fused to titanium and titanium alloys	D6084
	Implant supported crown - predominantly base alloys	D6086
	Implant supported crown - noble alloys	D6087
	Implant supported crown - titanium and titanium alloys	D6088
	Abutment supported crown - titanium and titanium alloys	D6094
	Abutment supported crown - porcelain fused to titanium and titanium alloys	D6097
	Frequency	
	Limited to 1 replacement for implants, partial dentures, and bridges per tooth per 5 years.	
	Limitation	
	Benefits may be based on the corresponding non-cosmetic restoration.	
Major	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	D6080
	Frequency	
	Maximum of 1 procedure per prosthesis, per 6 months.	
	Limitation	
Basic	Re-Cement or re-bond implant/abutment supported crown	D6092
	Frequency	
	Maximum of 1 procedure per 12 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	

Adjunctive General Services		
Procedure Class	Covered Procedure Description	ADA Code
Preventive	Palliative (emergency) treatment of dental pain - minor procedure	D9110
	Frequency	
	Maximum of 1 procedure per 12 months.	
	Limitation	
Basic	Deep sedation/general anesthesia - first 15 minutes	D9222
	Deep sedation/general anesthesia - each subsequent 15 minute increment	D9223
	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	D9239
	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	D9243

	Frequency
	Limitation
	Covered for complex oral surgery, periodontal surgery or impactions, only under specific conditions (pre-estimate recommended). Clinical records, including anesthesia information, will be required for consideration.



Group Dental Insurance Schedule of Covered Procedures

The following Schedule of Covered Procedures describes each procedure for which benefits are payable. All claims for Covered Procedures are subject to review. In addition, Covered Procedures are subject to the applicable Frequencies and Limitations. Procedure Frequencies are determined on a rolling basis, beginning on the date of service for that Covered Procedure.

Diagnostic		
Procedure Class	Covered Procedure Description	ADA Code
Preventive	Periodic oral evaluation - established patient	D0120
	Oral evaluation for a patient under three years of age and counseling with primary caregiver	D0145
	Frequency	
	Limited to any 2 of these procedure codes per 12 months. D0150 is included in this limitation.	
	Limitation	
Preventive	Comprehensive oral evaluation - new or established patient	D0150
	Frequency	
	Limited to any 2 of these procedure codes per 12 months per provider. D0120 and D0145 are included in this limitation.	
	Limitation	
Preventive	Comprehensive periodontal evaluation - new or established patient	D0180
	Frequency	
	Maximum of 1 procedure per 12 months.	
	Limitation	
Preventive	Limited oral evaluation - problem focused	D0140
	Detailed and extensive oral evaluation - problem focused, by report	D0160
	Re-Evaluation - limited, problem focused (established patient; not post-operative visit)	D0170
	Frequency	
	Limited to any 1 of these procedure codes per 12 months.	
	Limitation	
	An alternate benefit may be provided.	
Basic	Intraoral - complete series of radiographic images	D0210
	Frequency	
	Limited to any 1 of D0210 or D0330 per 36 months.	
	Limitation	
Preventive	Intraoral - periapical first radiographic image	D0220
	Intraoral - periapical each additional radiographic image	D0230
	Frequency	
	Maximum of 7 images combined D0220 and D0230 per visit.	
	Limitation	
	If 8 or more images in combination of D0220, D0230, D0270, D0272, D0273, D0274, D0277 or any image done with a D0330 are taken during a single visit an alternate benefit of D0210 will be given.	
Preventive	Intraoral - occlusal radiographic image	D0240
	Frequency	
	Maximum of 2 procedure per 12 months.	
	Limitation	

Preventive	Bitewing - single radiographic image	D0270
	Bitewings - two radiographic images	D0272
	Bitewings - three radiographic images	D0273
	Bitewings - four radiographic images	D0274
	Frequency	
	Limited to any 1 of these procedure codes per 12 months up to 4 radiograph images per visit.	
Preventive	Limitation	
	If 8 or more images in combination of D0220, D0230, D0270, D0272, D0273, D0274, D0277 or any image done with a D0330 are taken during a single visit an alternate benefit of D0210 will be given.	
	Vertical bitewings - 7 to 8 radiographic images	D0277
	Frequency	
	Maximum of 1 procedure per 12 months in combination with D0270, D0272, D0273, and D0274.	
	Limitation	
Basic	An alternate benefit may be provided.	
	Panoramic radiographic image	D0330
	Frequency	
	Limited to any 1 of D0210 or D0330 per 36 months.	
	Limitation	
	If 8 or more images in combination of D0220, D0230, D0270, D0272, D0273, D0274, D0277 or any image done with a D0330 are taken during a single visit an alternate benefit of D0210 will be given.	
Major	2D oral/facial photographic image obtained intra-orally or extra-orally	D0350
	Frequency	
	Maximum of 1 procedure per lifetime.	
	Limitation	
Preventive	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	D0431
	Frequency	
	Maximum of 1 procedure per 12 months.	
	Limitation	
	Procedure is limited to Insureds age 40 and older.	
	Procedure is only covered when there is presence of suspicious lesions or for those who demonstrate risk factors for oral cancer.	

Preventive		
Procedure Class	Covered Procedure Description	ADA Code
Preventive	Prophylaxis - adult	D1110
	Prophylaxis - child	D1120
	Frequency	
	Limited to 2 procedures per 12 months in combination of D1110, D1120 and D4910.	
	Limitation	
	One additional prophylaxis or periodontal maintenance per year if Member is in second or third trimester of pregnancy. Written verification of pregnancy and due date from patient's physician and claim narrative from dentist must be submitted at time of claim.	
Preventive	Topical application of fluoride varnish	D1206
	Topical application of fluoride - excluding varnish	D1208
	Frequency	
	Limited to any 1 of these procedure codes per 12 months.	
	Limitation	
	Procedure is limited to Insureds under the age of 16.	
Preventive	Sealant - per tooth	D1351
	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	D1352
	Frequency	
	Limited to any 1 of these procedure codes per tooth, per 36 months.	
	Procedure covered only for permanent molar teeth which have no prior occlusal restoration.	
	Limitation	
	Procedure is limited to Insureds under the age of 16.	
	Alternate benefit may be given for D1352.	

Preventive	Space maintainer - fixed, unilateral - per quadrant	D1510
	Space maintainer - fixed - bilateral, maxillary	D1516
	Space maintainer - fixed - bilateral, mandibular	D1517
	Space maintainer - removable, unilateral - per quadrant	D1520
	Space maintainer - removable - bilateral, maxillary	D1526
	Space maintainer - removable - bilateral, mandibular	D1527
	Distal shoe space maintainer - fixed, unilateral - per quadrant	D1575
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	Limitation	
	Procedure covered only when used to hold space for permanent tooth after the loss of primary tooth.	

Restorative		
Procedure Class	Covered Procedure Description	ADA Code
Basic	Amalgam - one surface, primary or permanent	D2140
	Amalgam - two surfaces, primary or permanent	D2150
	Amalgam - three surfaces, primary or permanent	D2160
	Amalgam - four or more surfaces, primary or permanent	D2161
	Frequency	
	Limited to any 1 restoration (filling/reattachment) by tooth surface per 24 months.	
	Limitation	
Basic	Resin-Based composite - one surface, anterior	D2330
	Resin-Based composite - two surfaces, anterior	D2331
	Resin-Based composite - three surfaces, anterior	D2332
	Resin-Based composite - four or more surfaces or involving incisal angle (anterior)	D2335
	Frequency	
	Limited to any 1 restoration (filling/reattachment) by tooth surface per tooth per 24 months.	
	Limitation	
Major	Resin-Based composite crown, anterior	D2390
	Frequency	
	Maximum of 1 procedure per 5 years.	
	Limitation	
Basic	Resin-Based composite - one surface, posterior	D2391
	Resin-Based composite - two surfaces, posterior	D2392
	Resin-Based composite - three surfaces, posterior	D2393
	Resin-Based composite - four or more surfaces, posterior	D2394
	Frequency	
	Limited to any 1 restoration (filling/reattachment) by tooth surface per tooth per 24 months.	
	Limitation	
Basic	Gold foil - one surface	D2410
	Gold foil - two surfaces	D2420
	Gold foil - three surfaces	D2430
	Frequency	
	Limited to any 1 restoration (filling/reattachment) by tooth surface per tooth per 24 months.	
	Limitation	
	Benefits may be based on the corresponding non-cosmetic restoration.	
Major	Inlay - metallic - one surface	D2510
	Inlay - metallic - two surfaces	D2520
	Inlay - metallic - three or more surfaces	D2530
	Inlay - porcelain/ceramic - one surface	D2610
	Inlay - porcelain/ceramic - two surfaces	D2620
	Inlay - porcelain/ceramic - three or more surfaces	D2630
	Inlay - resin-based composite - one surface	D2650
	Inlay - resin-based composite - two surfaces	D2651
	Inlay - resin-based composite - three or more surfaces	D2652
	Frequency	

	Limited to 1 of these restorations including inlay, onlay, or any type of crown, per tooth per 5 years.	
	Limitation	
Major	Onlay - metallic - two surfaces	D2542
	Onlay - metallic - three surfaces	D2543
	Onlay - metallic - four or more surfaces	D2544
	Onlay - porcelain/ceramic - two surfaces	D2642
	Onlay - porcelain/ceramic - three surfaces	D2643
	Onlay - porcelain/ceramic - four or more surfaces	D2644
	Onlay - resin-based composite - two surfaces	D2662
	Onlay - resin-based composite - three surfaces	D2663
	Onlay - resin-based composite - four or more surfaces	D2664
	Frequency	
	Limited to 1 of these restorations including inlay, onlay, or any type of crown, per tooth per 5 years.	
	Limitation	
Major	Crown - resin with high noble metal	D2720
	Crown - resin with predominantly base metal	D2721
	Crown - resin with noble metal	D2722
	Crown - porcelain/ceramic	D2740
	Crown - porcelain fused to high noble metal	D2750
	Crown - porcelain fused to predominantly base metal	D2751
	Crown - porcelain fused to noble metal	D2752
	Crown - porcelain fused to titanium and titanium alloys	D2753
	Crown - 3/4 cast high noble metal	D2780
	Crown - 3/4 cast predominantly base metal	D2781
	Crown - 3/4 cast noble metal	D2782
	Crown - 3/4 porcelain/ceramic	D2783
	Crown - full cast high noble metal	D2790
	Crown - full cast predominantly base metal	D2791
	Crown - full cast noble metal	D2792
	Crown - titanium and titanium alloys	D2794
	Frequency	
	Limited to 1 of these restorations including inlay, onlay, or any type of crown, per tooth per 5 years.	
	Limitation	
Major	Re-Cement or re-bond inlay, onlay, veneer or partial coverage restoration	D2910
	Re-Cement or re-bond crown	D2920
	Frequency	
	Maximum of 1 procedure per tooth, per 12 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	
Major	Prefabricated stainless steel crown - primary tooth	D2930
	Prefabricated stainless steel crown - permanent tooth	D2931
	Prefabricated resin crown	D2932
	Prefabricated stainless steel crown with resin window	D2933
	Prefabricated esthetic coated stainless steel crown - primary tooth	D2934
	Frequency	
	Limited to any 1 of these restorations including inlay, onlay, or any type of crown, per tooth per 5 years.	
	Limitation	
Major	Protective restoration	D2940
	Frequency	
	Maximum of 1 procedure per tooth per 24 months.	
	Limitation	
Major	Core buildup, including any pins when required	D2950
	Frequency	
	Maximum of 1 procedure per tooth, per 5 years.	

	Limitation	
Major	Post and core in addition to crown, indirectly fabricated	D2952
	Prefabricated post and core in addition to crown	D2954
	Frequency	
	Limited to any 1 of these procedure codes per tooth, per 5 years.	
	Limitation	
Major	Labial veneer (resin laminate) - chairside	D2960
	Labial veneer (resin laminate) - laboratory	D2961
	Labial veneer (porcelain laminate) - laboratory	D2962
	Frequency	
	Limited to 1 of these restorations including any type of crown, per tooth per 5 years.	
Major	Crown repair necessitated by restorative material failure	D2980
	Veneer repair necessitated by restorative material failure	D2983
	Frequency	
	Maximum of 1 procedure each per tooth per 12 months.	
	6 months must have passed since initial placement/treatment.	
Major	Inlay repair necessitated by restorative material failure	D2981
	Frequency	
	Maximum of 1 procedure each per tooth per 12 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	
Major	Onlay repair necessitated by restorative material failure	D2982
	Frequency	
	Maximum of 1 procedure each per tooth per 12 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	

Endodontics		
Procedure Class	Covered Procedure Description	ADA Code
Major	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	D3220
	Frequency	
	Limited to any 1 of these procedures per tooth, per lifetime.	
	Limitation	
Major	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	D3230
	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	D3240
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	Limitation	
Major	Endodontic therapy, anterior tooth (excluding final restoration)	D3310
	Endodontic therapy, premolar tooth (excluding final restoration)	D3320
	Endodontic therapy, molar tooth (excluding final restoration)	D3330
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
Major	Limitation	

Major	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	D3332
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	Limitation	
Major	Retreatment of previous root canal therapy - anterior	D3346
	Retreatment of previous root canal therapy - premolar	D3347
	Retreatment of previous root canal therapy - molar	D3348
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	6 months must have passed since initial placement/treatment.	
	Limitation	
Major	Apicoectomy - anterior	D3410
	Apicoectomy - premolar (first root)	D3421
	Apicoectomy - molar (first root)	D3425
	Apicoectomy (each additional root)	D3426
	Frequency	
	Maximum of 1 procedure per tooth, per lifetime.	
	Limitation	
Major	Retrograde filling - per root	D3430
	Frequency	
	Maximum of 1 procedure per tooth root, per lifetime.	
	Limitation	
Major	Root amputation - per root	D3450
	Frequency	
	Maximum of 1 procedure per tooth root, per lifetime.	
	Limitation	

Periodontics		
Procedure Class	Covered Procedure Description	ADA Code
Major	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	D4210
	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	D4211
	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	D4240
	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	D4241
	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	D4260
	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	D4261
	Pedicle soft tissue graft procedure	D4270
	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	D4273
	Non-Autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	D4275
	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	D4277
	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	D4278
	Frequency	
	Limited to any 1 of these procedure codes per quadrant, per 24 months.	
	Limitation	
Major	Clinical crown lengthening - hard tissue	D4249

	Frequency	
	Maximum of 1 procedure per tooth, per 60 months.	
	Limitation	
Major	Periodontal scaling and root planing - four or more teeth per quadrant	D4341
	Periodontal scaling and root planing - one to three teeth per quadrant	D4342
	Frequency	
	Maximum of 1 procedure per quadrant, per 24 months.	
	Limitation	
Major	Procedures will not be covered if performed on the same day as comprehensive exams, prophylaxis, periodontal maintenance, or debridement.	
	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	D4346
	Frequency	
	Maximum of 1 procedure per quadrant, per 24 months.	
	Limitation	
Major	Procedures will not be covered if performed on the same day as comprehensive exams, prophylaxis, periodontal maintenance, scaling/root planing, or debridement.	
	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	D4355
	Frequency	
	Maximum of 1 procedure per lifetime	
	Limitation	
Major	Procedures will not be covered if performed on the same day as comprehensive exams, prophylaxis, periodontal maintenance, scaling/root planing, or debridement.	
	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	D4381
	Frequency	
	Maximum of 1 procedure per quadrant, per 12 months.	
	Limitation	
Major	Periodontal maintenance	
	D4910	
	Frequency	
	Limited to 2 procedures per 12 months in combination with D1110 and D1120.	
	Limitation	
Major	Procedure is limited to Insureds age 16 and older.	
	One additional prophylaxis or periodontal maintenance per year if Member is in second or third trimester of pregnancy. Written verification of pregnancy and due date from patient's physician and claim narrative from dentist must be submitted at time of claim.	

Oral & Maxillofacial		
Procedure Class	Covered Procedure Description	ADA Code
Basic	Extraction, coronal remnants - primary tooth	D7111
	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	D7140
	Frequency	
	Maximum of 1 procedure per tooth.	
	Limitation	
Major	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210
	Removal of impacted tooth - soft tissue	D7220
	Removal of impacted tooth - partially bony	D7230
	Removal of impacted tooth - completely bony	D7240
	Removal of residual tooth roots (cutting procedure)	D7250
	Frequency	
	Maximum of 1 procedure per tooth.	
	Limitation	
Major	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7310

	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311
	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320
	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7321
	Frequency	
	Limited to any 1 of these procedure codes per quadrant, per 24 months.	
	Limitation	
Major	Incision and drainage of abscess - intraoral soft tissue	D7510
	Frequency	
	Limitation	

Prosthodontics (removeable)		
Procedure Class	Covered Procedure Description	ADA Code
Major	Complete denture - maxillary	D5110
	Complete denture - mandibular	D5120
	Immediate denture - maxillary	D5130
	Immediate denture - mandibular	D5140
	Frequency	
	Limited to 1 procedure per arch, per 5 years including overdenture, implant/abutment supported denture.	
Major	Limitation	
	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	D5211
	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	D5212
	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	D5213
	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	D5214
	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	D5221
	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	D5222
	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	D5223
	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	D5224
	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	D5225
	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	D5226
	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	D5282
	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	D5283
	Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	D5284
	Removable unilateral partial denture - one piece resin (including clasps and teeth) - per quadrant	D5286
	Frequency	
	Limited to 1 procedure per arch per 5 years including replacement of teeth and acrylic on frameworks, partial overdentures, partial dentures, implants, mini-implants, implant /abutment supported partial dentures.	
	Limitation	
	An alternate benefit may be provided.	
Major	Adjust complete denture - maxillary	D5410
	Adjust complete denture - mandibular	D5411
	Adjust partial denture - maxillary	D5421

	Adjust partial denture - mandibular	D5422
	Frequency	
	Maximum of 1 procedure per arch per 6 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	
Major	Repair broken complete denture base, mandibular	D5511
	Repair broken complete denture base, maxillary	D5512
	Replace missing or broken teeth - complete denture (each tooth)	D5520
	Repair resin partial denture base, mandibular	D5611
	Repair resin partial denture base, maxillary	D5612
	Repair cast partial framework, mandibular	D5621
	Repair cast partial framework, maxillary	D5622
	Repair or replace broken retentive clasping materials - per tooth	D5630
	Replace broken teeth - per tooth	D5640
	Add tooth to existing partial denture	D5650
	Add clasp to existing partial denture - per tooth	D5660
	Frequency	
	Maximum of 1 procedure per tooth, per 12 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	
Major	Rebase complete maxillary denture	D5710
	Rebase complete mandibular denture	D5711
	Rebase maxillary partial denture	D5720
	Rebase mandibular partial denture	D5721
	Frequency	
	Maximum of 1 procedure each per 24 months.	
	6 months must have passed since initial placement/treatment.	
Major	Limitation	
	Reline complete maxillary denture (chairside)	D5730
	Reline complete mandibular denture (chairside)	D5731
	Reline maxillary partial denture (chairside)	D5740
	Reline mandibular partial denture (chairside)	D5741
	Reline complete maxillary denture (laboratory)	D5750
	Reline complete mandibular denture (laboratory)	D5751
	Reline maxillary partial denture (laboratory)	D5760
	Reline mandibular partial denture (laboratory)	D5761
	Frequency	
	Limited to any 1 of these procedure codes per arch, per 24 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	
Major	Tissue conditioning, maxillary	D5850
	Tissue conditioning, mandibular	D5851
	Frequency	
	Maximum of 1 procedure per 12 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	

Prosthodontics (fixed)		
Procedure Class	Covered Procedure Description	ADA Code
Major	Pontic - indirect resin based composite	D6205
	Pontic - cast high noble metal	D6210

	Pontic - cast predominantly base metal	D6211
	Pontic - cast noble metal	D6212
	Pontic - titanium and titanium alloys	D6214
	Pontic - porcelain fused to high noble metal	D6240
	Pontic - porcelain fused to predominantly base metal	D6241
	Pontic - porcelain fused to noble metal	D6242
	Pontic - porcelain fused to titanium and titanium alloys	D6243
	Pontic - porcelain/ceramic	D6245
	Pontic - resin with high noble metal	D6250
	Pontic - resin with predominantly base metal	D6251
	Pontic - resin with noble metal	D6252
	Frequency	
	Limited to any 1 of these procedure codes per 5 years including partial overdentures, partial dentures, implants, mini-implants, implant /abutment supported partial dentures, and bridges.	
	Limitation	
Major	Retainer - cast metal for resin bonded fixed prosthesis	D6545
	Retainer crown - porcelain/ceramic	D6740
	Retainer crown - porcelain fused to high noble metal	D6750
	Retainer crown - porcelain fused to predominantly base metal	D6751
	Retainer crown - porcelain fused to noble metal	D6752
	Retainer crown - 3/4 cast high noble metal	D6780
	Retainer crown - 3/4 cast predominantly base metal	D6781
	Retainer crown - full cast high noble metal	D6790
	Retainer crown - full cast predominantly base metal	D6791
	Frequency	
	Limited to any 1 of these procedure codes per 5 years including inlays, onlays, crowns, bridges and partial dentures.	
	Limitation	
Major	Retainer crown - indirect resin based composite	D6710
	Retainer crown - resin with high noble metal	D6720
	Retainer crown - resin with predominantly base metal	D6721
	Retainer crown - resin with noble metal	D6722
	Retainer crown - porcelain fused to titanium and titanium alloys	D6753
	Retainer crown - 3/4 cast noble metal	D6782
	Retainer crown - 3/4 porcelain/ceramic	D6783
	Retainer crown 3/4 - titanium and titanium alloys	D6784
	Retainer crown - full cast noble metal	D6792
	Retainer crown - titanium and titanium alloys	D6794
	Frequency	
	Limited to any 1 of these procedure codes per 5 years including inlays, onlays, crowns, bridges and partial dentures.	
	Limitation	
Major	Re-Cement or re-bond fixed partial denture	D6930
	Fixed partial denture repair necessitated by restorative material failure	D6980
	Frequency	
	Maximum of 1 procedure each per 12 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	

Implant Services		
Procedure Class	Covered Procedure Description	ADA Code
Major	Surgical placement of implant body: endosteal implant	D6010
	Surgical placement of mini implant	D6013
	Surgical placement: eposteal implant	D6040
	Surgical placement: transosteal implant	D6050
	Frequency	

	Limited to any 1 procedure for implants, partial dentures, and bridges per tooth, per lifetime.	
	Limitation	
Major	Prefabricated abutment - includes modification and placement	D6056
	Custom fabricated abutment - includes placement	D6057
	Frequency	
	Maximum of 1 procedure per tooth, per 5 years.	
	Limitation	
	Only covered if an implant is covered.	
Major	Abutment supported porcelain/ceramic crown	D6058
	Abutment supported porcelain fused to metal crown (high noble metal)	D6059
	Abutment supported porcelain fused to metal crown (predominantly base metal)	D6060
	Abutment supported porcelain fused to metal crown (noble metal)	D6061
	Abutment supported cast metal crown (predominantly base metal)	D6063
	Implant supported porcelain/ceramic crown	D6065
	Implant supported crown - porcelain fused to high noble alloys	D6066
	Frequency	
	Limited to 1 replacement for implants, partial dentures, and bridges per tooth per 5 years.	
	Limitation	
	Benefits may be based on the corresponding non-cosmetic restoration.	
Major	Abutment supported cast metal crown (high noble metal)	D6062
	Abutment supported cast metal crown (noble metal)	D6064
	Implant supported crown - high noble alloys	D6067
	Implant supported crown - porcelain fused to predominantly base alloys	D6082
	Implant supported crown - porcelain fused to noble alloys	D6083
	Implant supported crown - porcelain fused to titanium and titanium alloys	D6084
	Implant supported crown - predominantly base alloys	D6086
	Implant supported crown - noble alloys	D6087
	Implant supported crown - titanium and titanium alloys	D6088
	Abutment supported crown - titanium and titanium alloys	D6094
	Abutment supported crown - porcelain fused to titanium and titanium alloys	D6097
	Frequency	
	Limited to 1 replacement for implants, partial dentures, and bridges per tooth per 5 years.	
	Limitation	
	Benefits may be based on the corresponding non-cosmetic restoration.	
Major	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	D6080
	Frequency	
	Maximum of 1 procedure per prosthesis, per 6 months.	
	Limitation	
Major	Re-Cement or re-bond implant/abutment supported crown	D6092
	Frequency	
	Maximum of 1 procedure per 12 months.	
	6 months must have passed since initial placement/treatment.	
	Limitation	

Adjunctive General Services		
Procedure Class	Covered Procedure Description	ADA Code
Basic	Palliative (emergency) treatment of dental pain - minor procedure	D9110
	Frequency	
	Maximum of 1 procedure per 12 months.	
	Limitation	
Major	Deep sedation/general anesthesia - first 15 minutes	D9222
	Deep sedation/general anesthesia - each subsequent 15 minute increment	D9223
	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	D9239
	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	D9243

	Frequency
	Limitation
	Covered for complex oral surgery, periodontal surgery or impactions, only under specific conditions (pre-estimate recommended). Clinical records, including anesthesia information, will be required for consideration.

Orthodontics Benefit Rider

The Orthodontics Benefit Rider provides benefits for comprehensive and interceptive Orthodontics Covered Procedures related to an Insured's initial orthodontic treatment which may consist of diagnosis, evaluation, pre-care, and insertion of bands or appliances. The Takeover Benefit in the certificate does apply to benefits for Orthodontics.

This rider is made a part of the Group Dental Insurance policy and is subject to all provisions, limitations and exclusions, unless changed or added by this rider.

All references to provisions, sections, and defined terms have been capitalized. Defined terms that have been capitalized within this rider have the same meaning as the defined terms capitalized in the certificate of coverage unless changed or added by this Rider.

Policyholder: Diné Development Corporation

Policy Number: 974682 011

Policy Effective Date: January 1, 2025

Rider Effective Date: January 1, 2025

Eligible Group(s)

All Full-Time Employees in Active Employment in the United States working a minimum of 30 hours per week.

Eligibility All Insureds are eligible for benefits under this rider.

Orthodontics Coinsurance Orthodontics Coinsurance is the percentage of the Reimbursement for Covered Procedures paid after any required Orthodontics Deductible has been satisfied. The percentages for which the Policy Pays and Insured Pays for Orthodontics Covered Procedures are shown below.

Orthodontics Maximum Benefit The Orthodontics Maximum Benefit is the total amount of benefits that will be paid for Orthodontic Covered Procedures during an Insured's lifetime.

	Per Insured
Lifetime	\$1,500

Benefits end when orthodontic treatment ends or the Maximum Benefit is reached, whichever comes first. In the event an Insured reaches the Maximum Benefit, the Insured is responsible for all costs associated with Orthodontic Covered Procedures for the remainder of their lifetime.

The Maximum Benefit will apply even if coverage is interrupted.

Start of Covered Procedures Covered Procedures must be started while an Insured's coverage is in force.

Orthodontic Covered Procedures are considered to begin the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered, is considered to be started and completed on the date the orthodontic treatment is rendered.

Payment of Benefits

Benefits will be paid as follows:

- Initial orthodontic treatment: 25% of the lesser of the total billed amount or the Orthodontics Lifetime Maximum Benefits payable on the date of initial orthodontic treatment consisting of diagnosis, evaluation, pre-care and insertion of bands or appliances; and
- Ongoing treatment: Monthly based on the Reimbursement of Covered Procedures subject to Coinsurance, proof of continued treatment, and the Orthodontics Lifetime Maximum Benefit.

If orthodontic aligners are elected, benefits will be paid the same as fixed orthodontic appliances.

Insureds over the Eligibility age limitation may continue to receive benefits, provided:

- treatment started while the Insured was under the age limitation;
- treatment continues;
- coverage for orthodontic services remains in-force under the certificate;
- the Insured continues to be covered under the certificate; and
- the Orthodontics Maximum Benefit has not been reached.

Orthodontics Covered Procedures

Covered Procedure Description	ADA CODE
Limited orthodontic treatment of the transitional dentition	D8020
Limited orthodontic treatment of the adolescent dentition	D8030
Limited orthodontic treatment of the adult dentition	D8040
Interceptive orthodontic treatment of the primary dentition	D8050
Interceptive orthodontic treatment of the transitional dentition	D8060
Frequency & Limitations	
Limited to any 1 of these procedure codes per 3 years.	
Comprehensive orthodontic treatment of the transition dentition	D8070
Comprehensive orthodontic treatment of the adolescent dentition	D8080
Comprehensive orthodontic treatment of the adult dentition	D8090
Frequency & Limitations	
Limited to any 1 of these procedure codes per 3 years.	
Periodic orthodontic treatment visit	D8670
Frequency & Limitations	
Exposure of an unerupted tooth	D7280
Frequency	
Maximum 1 procedure per tooth, per lifetime.	
Limitation	
2D cephalometric radiographic image - acquisition, measurement and analysis	D0340
Frequency	
Maximum of 1 procedure per banding per 3 years.	
Limitation	
3D photographic image	D0351
Frequency	
Maximum of 1 procedure per banding per 3 years.	
Limitation	
Diagnostic casts	D0470
Frequency	
Maximum of 1 procedure per banding per 3 years.	
Limitation	
Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	D0250
Frequency	

Limitation

Summary Plan Description - Supplement Information

This Supplement is intended to provide you with additional information regarding the dental benefit plan (the "Plan") that is not addressed in your Certificate of Coverage. Capitalized terms not defined in this Supplement have the meaning set forth in the Certificate of Coverage.

This Supplement, together with your Certificate of Coverage, constitutes the Summary Plan Description ("SPD") for the Plan. An SPD is intended to provide you with important Plan information as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The Plan document consists of the Certificate of Coverage and the Policy and, if applicable, your employer's umbrella or "wrap" plan document. Benefits are determined by the Policy, your Certificate of Coverage and the information contained in this document.

If there is a conflict between the SPD and Policy, the terms of the Policy will control with the exception that the grant of discretionary authority in the SPD will always control with respect to the interpretation and administration of the Policy and all benefit determinations made under the Policy.

This SPD and the Plan document, Policy, Certificate of Coverage, and other applicable documentation may be amended at any time.

Name of Plan:

Diné Development Corporation Health and Welfare Benefit Plan Plan

Name and Address of Employer:

Diné Development Corporation
8840 E Chaparral Rd
Suite 145
Scottsdale, Arizona
85250

Plan Identification Number:

- a. Employer IRS Identification #: 77-0651649
- b. Plan #: 501

Type of Welfare Plan:

Dental

Type of Administration:

The Plan is administered by the Plan Administrator. Benefits are administered by the Claims Administrator, and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends:

December 31

Plan Administrator, Name, Address, and Telephone Number:

Diné Development Corporation
8840 E Chaparral Rd
Suite 145
Scottsdale, Arizona
85250
(717) 262-9750

Diné Development Corporation is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan if Plan assets are held in trust, in which case the Administrator will advise you separately of the name, title and address of each Trustee. In the event the benefits under the Plan are subject to collective bargaining, You may request a copy, or request to examine a copy, of the collective bargaining agreement by contacting the Plan Administrator.

Agent for Service of Legal Process on the Plan:

Diné Development Corporation

8840 E Chaparral Rd
Suite 145
Scottsdale, Arizona
85250

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

Funding and Contributions

Benefits are provided through an insurance contract issued by Starmount Life Insurance Company, 8485 Goodwood Blvd., Baton Rouge, LA 70806 under policy number 974682 011. Contributions to the Plan are made as stated under Paying for Coverage in the Certificate of Coverage.

Eligibility for Participation and Summary of Benefits

Refer to the Certificate of Coverage (including its Schedule of Benefits and Schedule of Covered Procedures) for provisions dealing with eligibility for benefits and for a description of benefits payable under the dental options under the Plan.

QMCSO Procedures

A qualified medical child support order ("QMCSO") is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits, which may include dental benefits, and meets certain requirements under ERISA. Generally, a QMCSO is issued as a part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO and then take steps to notify you of the QMCSO determination and corresponding enrollment if required.

You may obtain, without charge, a copy of procedures governing QMCSOs from the Plan Administrator.

Extension of Certain Deadlines Due to COVID-19

Certain deadlines provided in this document and in the Certificate of Coverage may be extended due to guidance provided by the Internal Revenue Service, Department of Labor, Department of the Treasury, Department of Health and Human Services, or other governmental body with proper authority to extend such deadlines (the "Departments"). Pursuant to guidance issued by the Departments on May 4, 2020, the Departments have extended deadlines for you to file certain claims and appeals, certain deadlines related to COBRA, and certain deadlines related to your special enrollment rights under HIPAA, due to COVID-19. The Departments require the otherwise applicable deadlines to be disregarded during the "Outbreak Period." Subject to the statutory duration limitation in ERISA Section 518 and Code Section 7508A, "Outbreak Period" is the period beginning on March 1, 2020, and ending 60 days after the announced end or the expiration of the National Emergency. The Plan will comply with all deadline extensions provided by the Departments, now and in the future. Please contact the Claims Administrator with any questions about the extension of these deadlines.

Filing a Claim Under Your Plan

If you wish to file a claim for benefits, you should follow the claims procedures described in the Certificate of Coverage. If your Certificate of Coverage has been lost or misplaced, please contact the Employer identified above.

Claims and Appeals Procedures for Plans Covered by ERISA

If your Plan is subject to ERISA, the following requirements will apply (in addition to the requirements in your Certificate of Coverage) with respect to claims made under the Plan. "Your" and "you" in this section include any Insured (as defined in the Certificate of Coverage) or an authorized representative of an Insured. The term "claimant" may also be used for this purpose.

There are two types of claims for benefits under the Plan:

1. Urgent Care Claim - An Urgent Care Claim is any claim for medical care (which includes dental care) or treatment with respect to which lack of immediate processing of the claim could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

Except with respect to Claims determined by physician with knowledge of the claimant's medical condition to be Urgent Care Claims, whether a claim is an Urgent Care Claim is to be determined by the Claims Administrator applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

2. Post-Service Claim - A Post-Service Claim is any claim that does not require approval (in whole or in part) in advance of obtaining the dental care. All claims under the Plan are Post-Service Claims, except for Urgent Care Claims.

Notification of Initial Decision. For Urgent Care Claims, you will be notified of the Claims Administrator's initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event more than 72 hours after the Claims Administrator receives the claim. If the claim does not include sufficient information for the Claims Administrator to determine whether, or to what extent, benefits are covered or payable under the Plan, you will be notified within 24 hours after receipt of the claim of the need to provide additional information and the specific information necessary to complete the claim. You will have at least 48 hours to respond to this request; the Claims Administrator then will inform you of its decision within 48 hours of receiving the additional information or, if earlier, the end of the period afforded to you to provide the specified additional information.

For Post-Service Claims, you will receive a response within 30 days after the claim is received by the Claims Administrator unless it determines that additional time is necessary (of up to 15 days) to make a decision regarding the claim due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension and the date by which it expects to render a decision. If an extension is necessary because you failed to include the information necessary to decide the claim, the notice of extension will describe the information necessary from you and will provide at least 45 days to provide the specified information.

For all types of claims, the time period beginning on the date which the Claims Administrator notifies you of the need for additional information and ending on the date you provide such additional information is not included in computing the time frame in which the Claims Administrator will respond to the claim.

Denial of Initial Claim. If the Claims Administrator denies all or any part of your claim, you can access the claim status detail on www.AlwaysAssist.com. You have the right to receive a Written notice of denial setting forth:

- the specific reason(s) for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits applicable to such procedures;
- a statement of your right to bring a civil action under section 502(a) of ERISA following the denial of your claim on appeal;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a copy of that specific rule, guideline, protocol, or other similar criterion, or a statement that such specific rule, guideline, protocol, or other similar criterion was relied upon in denying your claim and that a copy of such specific rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;
- if your claim was denied based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgement underlying the claim denial, as applied to your medical circumstances, or a statement that you will be provided such explanation free of charge upon request; and
- for Urgent Care Claims, a description of the Plan's expedited review process applicable to such claims.

To request a copy of the criterion or medical judgment summary, please contact the Claims Administrator.

Upon receipt of a claim denial you have the right, upon request and free of charge, to receive copies of all documents, records, and other information relevant to your claim for benefits.

Appeal. If, under the terms of the Plan, a claim is denied in whole or in part, a request may be submitted to the Claims Administrator by you, or by your authorized representative, for a full and fair review of the denial (i.e., an appeal). You may designate any person, including your Provider, as your authorized representative.

The request must be made within 180 days following your receipt of adverse benefit determination, must be Written unless the claim is an Urgent Care Claim (in which case the request may be made orally, by telephone, fax, email or other reasonable method), and should contain sufficient information to identify the person for whom the claim was submitted, including:

- your or your Spouse's or Children's name;
- your or your Spouse's or Children's identification number and date of birth;
- the Provider of services; and
- the claim number.

An Insured may request, free of charge, any documents held by the Claims Administrator regarding the denial of your claim. You [or your Spouse or Children or an authorized representative] may also submit Written comments, documents, records, or other information concerning the claim.

An appeal will not afford deference to the initial denial of the claim, and will be decided by someone who is different from, and who is not a subordinate of, the individual who made the initial decision on the claim. Also, if the appeal is based in whole or in part on a medical judgment, including determinations with regard to whether a particular drug, treatment, or other item is experimental, investigational, or not medically necessary or appropriate, then the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not be the same as any health care professional who was consulted in connection with the initial claims denial, nor a subordinate of that professional. If the appeal is denied, you will be advised if any medical or vocational expert's advice was obtained on behalf of the Plan, including the identity of any such medical or vocational expert, in connection with the appeal, regardless of whether the advice was relied on by the Plan.

The Claims Administrator's response to your request for review, including specific reasons for the decision and reference to the specific plan provision on which the benefit determination is based, shall be provided and communicated to you or your Spouse or Children no later than:

1. Urgent Care Claims - not later than 72 hours after receiving the request for a review.
2. Post-Service Claims - not later than 60 days after receiving the request for a review.

The Claims Administrator will consider the appeal, taking into account all comments, documents, records, and other information submitted, including information not submitted or considered in the initial decision on the claim. The Claims Administrator will not defer to the initial decision to deny the claim. Any decision made by the Claims Administrator on appeal will be final and conclusive.

If the Claims Administrator denies all or any part of your claim on appeal, you can access the claim status detail on www.AlwaysAssist.com. You have the right to receive a Written notice of denial setting forth:

- the specific reason(s) for the denial;
- reference to the specific Plan provisions upon which the denial was based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- a statement describing any other voluntary appeal procedures offered under the Plan and your right to obtain the information about such procedures;
- a statement of your right to bring a civil action under section 502(a) of ERISA;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a copy of that specific rule, guideline, protocol, or other similar criterion, or a statement that such specific rule, guideline, protocol, or other similar criterion was relied upon in denying your claim and that a copy of such specific rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and
- if your claim was denied based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgement underlying the claim denial, as applied to your medical circumstances, or a statement that you will be provided such explanation free of charge upon request.

To request a copy of the criterion or medical judgment summary, please contact the Claims Administrator.

Legal Action

If you believe your claim under the Plan is being improperly denied in whole or in part, you have the right to bring a legal action, subject to any time bar to bringing suit set forth in the Certificate of Coverage. However, no legal action can be brought until you have exhausted all the steps in the appeal process provided under the Plan.

Plan Administration

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, having the sole discretionary authority (except to the extent delegated) to interpret the Plan, prescribe applicable procedures, determine eligibility for and the amount of benefits, authorize benefit payments, gather information necessary for administering the Plan, and determine all questions in the administration, interpretation and application of the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The Plan grants to itself the discretionary authority to make all benefit determinations under the Plan.

All determinations of the Plan Administrator or its delegate shall be conclusive and binding on all parties.

Claims Administrator

The Plan, acting through the Plan Administrator, delegates to the Starmount Life Insurance Company and its affiliate Unum Group (collectively, the Claims Administrator") the discretionary authority to make all benefit determinations pursuant to the Plan documents, which include insurance policies and other documents evidencing funding for benefits provided under the Plan. The Claims Administrator may act directly or through its parents, affiliates, employees and agents or further delegate its authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and applying Plan terms and conditions. Exercising discretionary authority requires that a benefit determination must be made on a principled and reasoned basis, consistent with a reasonable interpretation of the terms of the Plan or insurance policy, and supported by the facts and circumstances of each claim.

Starmount Life Insurance Company
8485 Goodwood Blvd.
Baton Rouge, LA 70806
(888) 400-9304

COBRA Administrator

The Plan, acting through the Plan Administrator, has delegated to the COBRA Administrator the authority to administer COBRA continuation coverage (described below). The COBRA Administrator is identified in the initial COBRA notice that is provided to employees (and spouses, as applicable) at the time coverage is commenced under the Plan ("Initial COBRA Notice").

Employer's Right to Amend the Plan

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. No provision of the Plan or any of its related documents shall create any vested rights in any employee, retiree, participant, or any other person. No consent of any participant is required to terminate, modify, amend or change the Plan. The Plan may be amended, modified or terminated by written instrument duly adopted by the Employer or any of its delegates.

Family Medical Leave Act of 1993 (FMLA)

If a covered employee ceases active employment due to an employer-approved Family Medical Leave of Absence in accordance with the requirements of the FMLA, coverage will be continued under the same terms and conditions which would have applied had the employee continued in active employment, provided the employee continues to pay his share of the premium for the cost of coverage, in accordance with the rules for any required contributions. Contributions will remain at the same employer/employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other employees in the same classification).

Continuation of Coverage under COBRA

A federal law called "COBRA" requires the Plan to offer employees and their dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan otherwise would end due to the occurrence of a "qualifying event".

You and your covered spouse or domestic partner and covered dependents will be entitled to continue benefits under this Plan upon the occurrence of a qualifying event, as described further below. You may continue only the Plan coverage in effect at the time and must pay required premiums.

General

If you are a Qualified Beneficiary, you have the right to continue your coverage under the Plan if you lose that coverage due to a "Qualifying Event". If you are an employee, you are a Qualified Beneficiary if you are covered by the Plan on the day prior to a Qualifying Event that is your termination of employment (for reasons other than gross misconduct) or a reduction in your hours of employment. If you are the spouse or domestic partner (in the event domestic partner coverage is provided under the Plan) or dependent child of an employee, you are a Qualified Beneficiary if you are covered by the Plan on the day prior to a Qualifying Event. A child born to or placed for adoption with an employee during a period of COBRA coverage is also a Qualified Beneficiary.

A "Qualifying Event" means each of the following events, if it causes a Qualified Beneficiary to lose coverage under the Plan: (i) your reduced hours of employment, (ii) your employment ends for any reason other than gross misconduct, (iii) your death, (iv) your entitlement to Medicare benefits (v) your divorce or legal separation from your spouse or termination of domestic partnership, or (vi) for a dependent child, the child's ceasing to satisfy the definition of a dependent under the terms of the applicable program.

If you are a Qualified Beneficiary and you lose coverage under the Plan due to the first four Qualifying Events listed above, you will automatically receive a Qualifying Event notice from the COBRA Administrator of your right to elect COBRA continuation coverage. However, if you are a Qualified Beneficiary and you lose coverage under the Plan due to a divorce or legal separation, or due to a child's loss of dependency status, you must notify the COBRA Administrator of the event within 60 days after the Qualifying Event occurs or you will lose your right to elect COBRA continuation coverage.

Electing COBRA Coverage

If you are a Qualified Beneficiary and you experience a Qualifying Event, you will receive a Qualifying Event Notice and election form describing your rights to elect COBRA continuation coverage. Remember, if the Qualifying Event is a divorce, legal separation, or a child's loss of dependency status, you must first notify the COBRA Administrator of the event before this notice will be sent to you. If you do not receive a Qualifying Event Notice and election form within 30 days of your Qualifying Event (or within 14 days of the date you notified the COBRA Administrator of a Qualifying Event, if applicable), you should contact the COBRA Administrator.

Although each Qualified Beneficiary has an independent right to elect COBRA coverage, the Qualifying Event Notice and election form will usually only be sent to the employee and spouse or domestic partners, at the employee's address shown in the records of the Plan. For this reason, it is very important that you keep the COBRA Administrator informed of your current address and the addresses of your spouse and covered dependents. Covered employees may elect COBRA continuation coverage on behalf of their spouses and domestic partners, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA coverage will be provided only if it is elected by a Qualified Beneficiary during the COBRA election period. The COBRA election period begins on the date of the Qualifying Event and ends 60 days after the date a Qualifying Event Notice and election form is sent to the Qualified Beneficiary or, if later, the date the Qualified Beneficiary would otherwise lose coverage as a result of the Qualifying Event. For elections sent by mail, the postmark date is used to determine whether an election was made prior to the end of the COBRA election period.

If elected, COBRA coverage begins on the date coverage would otherwise have been lost.

Prior to the time a Qualified Beneficiary elects COBRA coverage, his or her coverage under the Plan will be terminated. However, the coverage will be retroactively reinstated to the date coverage was lost following a

timely election of COBRA coverage and the timely payment by the Qualified Beneficiary of the first premium payment.

Paying for COBRA Coverage

Qualified Beneficiaries must pay for each one-month period of COBRA coverage on a monthly basis. A period of COBRA coverage runs from the first day of the month through the end of that month, except that the initial period of coverage runs from the date coverage was lost due to the Qualifying Event, through the end of the month in which the Qualifying Event occurred.

The cost for each one-month period of COBRA coverage (which may change at the beginning of each Plan Year) depends on the type of coverage that is being continued and will be communicated to you.

In order to maintain your right to COBRA coverage, the first payment for COBRA coverage must be postmarked or received by the Plan no later than 45 days after the date you elect COBRA coverage (including payment for all one-month periods of coverage that have begun between the date coverage was lost and the date the first premium payment is received).

Payments for subsequent one-month periods are due on the first day of those periods. You will have a 30-day grace period to make monthly payments otherwise COBRA coverage will be terminated retroactively to the first day of that period and cannot be reinstated. Any payment that is less than the full premium payment due will not be accepted unless the balance is paid prior to the end of the normal grace period. Please refer to the Initial COBRA Notice for further details on coverage in the event payment is received during the grace period.

Duration of COBRA Coverage

When the Qualifying Event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse or domestic partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- If you or anyone in your family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the COBRA Administrator is notified of the SSA's determination before the end of the 18-month period of COBRA continuation coverage and not later than 60 days after the latest of (i) the date of the disability determination by the SSA, (ii) the date on which a Qualifying Event occurs, or (iii) the date on which you or another Qualified Beneficiary loses (or would lose) coverage under the program as a result of the Qualifying Event. If a Qualified Beneficiary who was previously determined by the SSA to be disabled is subsequently determined by the SSA to be no longer disabled, you must notify the COBRA Administrator of that determination within 30 days of the date you receive the determination from the SSA.
- If your family experiences another Qualifying Event while receiving COBRA continuation coverage, the spouse (or domestic partner) and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available only if the second event would have caused the spouse (or domestic partner) or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. In all of these cases, you must make sure that the COBRA Administrator is notified of the second Qualifying Event within 60 days of the event. Only individuals

who were Qualified Beneficiaries in connection with the first Qualifying Event and who are still Qualified Beneficiaries at the time of the second Qualifying Event are eligible for this extension.

COBRA coverage will end prior to the 18-, 29- or 36-month period described above under the following circumstances: (i) the first day of a coverage period for which timely payment is not made, (ii) the date the Plan Sponsor ceases to provide any group health plan to you, (iii) the date, after the date a COBRA election is made, upon which the Qualified Beneficiary first becomes covered under another group health plan or entitled to Medicare benefits; (iv) the first day of the coverage period that is more than 30 days after the date a Qualified Beneficiary entitled to a disability extension is finally determined to not be disabled; or (v) the date coverage is terminated for cause.

If the COBRA coverage of a Qualified Beneficiary terminates early, the COBRA Administrator will send a notice regarding the termination of COBRA coverage to you as soon as practicable.

How to Notify the COBRA Administrator

You must send written notice* of a Qualifying Event that is a divorce, a legal separation, or a child's loss of dependent status, to the COBRA Administrator within 60 days of the event. Also, if you elect COBRA coverage and you are eligible for an 11-month extension of that coverage due to the disability of a Qualified Beneficiary, or for an 18-month extension of that coverage due to the occurrence of a second Qualifying Event, you must provide written notice of the disability determination or the second Qualifying Event to the COBRA Administrator. Notice must be sent by first class mail or other nationally-recognized courier service, by fax, e-mail or by hand-delivery. Oral notice will not be accepted. Your notice must include your name and the names of other affected family members, the type of Qualifying Event and written documentation of the event that identifies the date on which the event occurred. You should keep a copy, for your records, of any notices you send to the COBRA Administrator.

Any notices required to be provided to the COBRA Administrator may be provided by the employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of either of them, and will be sufficient for all beneficiaries affected by the same Qualifying Event.

*The COBRA Administrator will determine the form of the written notice. For example, the COBRA Administrator may determine that written notice includes providing notice through the COBRA Administrator's online platform.

The contact information for the COBRA Administrator is in the Initial COBRA Notice.

If You Have Questions

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Under USERRA

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Under USERRA, you have certain rights regarding continuance of Plan benefits while you are on a leave of absence for military service or uniformed service (referred to herein as a "military leave of absence"). The terms "uniformed services" or "military service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If you are absent from work for less than 31 days due to your active military service, your Plan participation will be continued at active employee rates. If your absence is for 31 days or more, you and your covered family members will have the opportunity to elect continuation group health coverage for up to 24 months or the period of your military service, whichever is shorter; provided, you pay up to 102% of the normal premium for this continued coverage. If you elect not to continue coverage under the Plan, your coverage will be reinstated to the extent required under USERRA upon your return to employment.

USERRA continuation coverage is considered to be alternative coverage for COBRA purposes. As a result, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Please refer to the applicable booklet for more information about continuation coverage available under USERRA.

Successors and Assigns

Except as otherwise provided in the Plan or under applicable law, all benefits, rights, or interests of Participants under the Plan are expressly non-assignable, non-transferable, including to any dental care provider, and shall not be subject to anticipation, alienation, sale, transfer, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities, or other obligations of such participants, and accordingly the right of any Participant to receive any benefits under the Plan shall not be subject to any claims by any creditor of or claimant against the participant. Any attempt to assign, transfer, anticipate, alienate, sell, pledge, encumber, charge, garnish, execute, or levy upon, or otherwise dispose of any rights, benefits, or causes of action under the Plan shall be void and unenforceable. This prohibition applies to all rights and interests under the Plan, including rights to benefits, claims for fiduciary breach, claims for statutory penalties, and any other rights that may be asserted by a participant under or related to the Plan. Nothing in this provision prevents a Claims Administrator, in its sole discretion, from paying dental benefits directly to a dental care provider that provides services to a participant, but a participant has no authority or right to obligate the Claims Administrator to make direct payment to a dental care provider and any attempt to obligate a Claims Administrator to make direct payment to a dental care provider is void and unenforceable. Further, the Plan does not create any right or legal relationship or third-party beneficiary status between the Employer or any Claims Administrator and any dental care providers.

Tax Consequences and Withholding

The Employer does not guarantee the federal, state, or local tax treatment of any benefits provided under the Plan. Benefits provided under the Plan shall be subject to federal, state, or local income tax withholding or employment tax withholding in accordance with the rules applied to such benefits as interpreted by the Employer under applicable federal, state, or local laws.

Your Rights Under ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Dental Coverage

Continue dental care coverage for yourself, spouse or domestic partner or dependents if there is a loss of coverage under the Plan as a result of a qualifying event if the Plan is subject to COBRA. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court after exhausting the Plan's claims procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Privacy Notice

This Privacy Notice applies to Unum Group's United States insurance operations and is being provided on behalf of its affiliates listed below ("Unum" "we"), as required by the Gramm-Leach Bliley Act and state insurance laws. This Notice describes how we collect, share, and protect nonpublic personal information (NPI).

COLLECTING INFORMATION

We collect NPI about our customers to provide them with insurance products and services, perform underwriting, provide stop loss coverage, and administer claims. The types of NPI we collect for these purposes may include telephone number, address, Social Security number, date of birth, occupation, income, and medical history, including treatment. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

SHARING INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us perform underwriting, provide stop loss coverage, pay claims, detect fraud, and to provide reinsurance or auditing. We may share NPI with medical providers for insurance and treatment purposes and with insurance support organizations. The organizations may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes, with parties for a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

SAFEGUARDING INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

ACCESS TO INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing, providing your full name, address, telephone number and policy number, to the address below. We will reply within 30 business days of receipt. If you request, we will send copies of the NPI to you or make available to you at our office. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTION OF INFORMATION

If you believe the NPI we have about you is incorrect, please write to us and include your full name, address, telephone number and policy number if we have issued a policy, and the reason you believe the NPI is inaccurate. We will reply within 30 business days of receipt. If we agree with you, we will correct the NPI and

notify you and insurance support organizations that may have received NPI from us in the preceding 7 years. We will also, if you ask, notify any person who may have received the incorrect NPI from us in the past 2 years.

If we disagree with you, we will tell you we are not going to make the correction and the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct and the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI to be accessible. We will include your statement any time the disputed NPI is reviewed or disclosed. We will also give the statement to insurance support organizations that gave us NPI and to any person designated by you, if we disclosed the disputed NPI to that person in the past two years.

COVERAGE DECISIONS

If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI. You may submit a written request for the reason(s) for our decision within 90 business days of our decision. We will reply within 21 business days of receipt with the specific reasons, if not initially furnished, and specific items of information that supported our decision.

CONTACTING US

For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, B267, Portland, Maine 04122 or at Privacy@unum.com.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and Starmount Life Insurance Company.

2020 Unum Group. All rights reserved. Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

unum.com

MK-1883 (06-2020)

Accessibility Services

Hearing Impairment

We utilize a TTY line for communication with individuals who are hearing-impaired. Insureds may initiate a call through the TTY by calling a toll-free number or, in the event a call is received from a hearing-impaired individual on our standard Member Services line, the Member Services representative initiates a call to the TTY Service.

Other Special Needs

Insureds face many special needs, many of which cannot be foreseen and planned for. As we, our clients, and our participating providers identify insureds with special needs, we will make such arrangements as are necessary to provide equal access to administrative and vision/dental care services as are provided to insureds who do not have special needs. Due to varying individual needs, the nature of such arrangements is determined on a case-by-case basis pursuant to the special need identified. Such arrangements may include providing documents in large font format or allowing an insured to receive services from a non-participating provider, as appropriate to the situation and within the benefits provided in the Certificate of Insurance.

Interpretation & Translation

Notice Regarding Translator and Interpretation Services

We offer interpreter service for non-English speaking members. Our service interprets over 180 languages and dialects. If you require language assistance, please contact our customer service department at (888) 400-9304 to be connected to an interpreter.

Spanish

Noticia en Relación de Servicios traductores y Interpretes

Ofrecemos servicios de intérpretes para los miembros que no hablan inglés. Nuestro servicio interpreta más de 180 idiomas y dialectos. Si usted requiere asistencia lingüística, por favor contacte nuestro departamento de servicios de atención al cliente al (888) 400-9304 para ponerse en contacto con un intérprete.

Russian

Уведомление об услугах устного и письменного перевода

Мы готовы предложить услуги переводчиков участникам, которые не говорят на английском языке. Выполняем переводы с и на более 180 языков и диалектов. Если вам нужна помощь переводчика, свяжитесь с ним, позвонив в наш отдел обслуживания клиентов по номеру: (888) 400-9304.

French

Avis concernant les traducteurs et les services d'interprétations

Nous proposons des services d'interprétation aux membres ne parlant pas l'anglais. Nous sommes en mesure de traduire dans plus de 180 langues et dialectes. Si vous avez besoin d'une assistance linguistique, veuillez contacter notre service clients au (888) 400-9304 pour être mis en relation avec un interprète.

Khmer (Cambodian)

យើងខ្ញុំផ្តល់ជូន យោបល់ប្រកាសយល់ ដល់មាត់ រមែងមោឃិតប្រល័យមិននិយាយ ភាសាអង់គ្លេស
យោបល់យើងខ្ញុំ បានប្រកាស និងរាមភាសាជាង 180 ភាសា។ បរិយាយប្រើយោបល់អន្តរាគមន៍ការផ្តល់ ភាសា
រួមទាំងទម្រង់ប្រកាសយោបល់អតិថិជនរបស់យើងតាមលេខ (888) 400-9304
យើងប្រើប្រាស់យោបល់និងអន្តរាគមន៍ប្រកាស។

ແຈ້ງການກ່ຽວກັບການບໍລິການເປພາສາແລະນັກເປພາສາ

Haitian

Nou ofri sèvis entèprèt pou manm ki pa pale anglè. Sèvis entèprèt nou an genyen plis pase 180 lang ak dyalèk. Si w bezwen asistans nan domèn lang, tanpri kontakte depatman sèvis kliyan nou an nan (888) 400-9304 pou yo konekte w ak yon entèprèt.

نحن نقدم خدمة الترجمة الشفوية للأعضاء غير الناطقين باللغة الإنجليزية. تتوفر خدمتنا بأكثر من 180 لغة ولهجة. إذا كنت بحاجة إلى المساعدة اللغوية، يرجى الاتصال بقسم خدمة العملاء لدينا على الرقم 3049 - 400 (888) (لن يتم توصيلك بمترجم شفوي

Ανακοίνωση σχετικά με τις υπηρεσίες μετάφρασης και διερμηνείας

Προσφέρουμε υπηρεσίες διερμηνείας στα μέλη μας που δεν μιλούν την αγγλική γλώσσα. Η υπηρεσία μας αναλαμβάνει τη διερμηνεία για πάνω από 180 γλώσσες και διαλέκτους. Αν χρειάζεστε γλωσσική βοήθεια, παρακαλούμε να επικοινωνήσετε με το τμήμα εξυπηρέτησης πελατών της εταιρείας μας στον αριθμό (888) 400-9304 και να ζητήσετε να συνδεθείτε με έναν διερμηνέα.

Nota relative ai servizi di traduzione e interpretariato

Offriamo servizi di interpretariato per membri non di lingua inglese. I nostri interpreti sono in grado di lavorare con più di 180 lingue e dialetti. Se avete bisogno dell'assistenza linguistica, contattate il nostro reparto di assistenza clienti al numero (888) 400-9304 per essere inoltrati ad un interprete.

Aviso relacionado aos serviços de tradutor e intérprete

Oferecemos serviço de intérprete para membros que não falam Inglês. O nosso serviço interpreta mais de 180 idiomas e dialetos. Se você precisar de assistência linguística, contate o nosso departamento de atendimento ao cliente no (888) 400-9304 para ser conectado a um intérprete.

关于提供译员和口译服务的通知

我们向非英语会员提供口译服务。该项服务涵盖 180 种语言和方言的口译。如果您需要语言方面的帮助，请拨打 (888) 400-9304 联系我们的客服部门，以与一位口译员进行连线通话

Gujarati

ભાષાંતર અને દુભાષણની સેવા સાંબાંધી સૂચના

અંગ્રેજી ના જાણતા હોય તેવા સભ્યો માટે અમે દુભાષણની સેવા આપીએ છીએ. અમે 180 ભાષાઓ અને બોલીઓમાં દુભાષણની સેવા આપીએ છીએ. જો આપને ભાષાસાંબાંધી મદદની જરૂર હોય તો, કૃપા કરી દુભાષણ સાથે વાત કરવા અમારી ગ્રાહક સેવા ષવભાગ (888) 400-9304 સંપર્ક કરો.

Vietnamese

Thông báo về Dịch vụ Thông dịch và Biên dịch

Chúng tôi cung cấp dịch vụ thông dịch cho các thành viên không nói tiếng Anh. Dịch vụ của chúng tôi thông dịch hơn 180 ngôn ngữ và thổ ngữ. Nếu quý vị cần hỗ trợ về ngôn ngữ, vui lòng liên hệ với bộ phận dịch vụ khách hàng của chúng tôi theo số (888) 400-9304 để được kết nối với một thông dịch viên.

Haitian Creole

Avi Anrapò Sèvis Tradiktè ak Entèpretasyon

Nou ofri sèvis entèprèt pou manb ki pa pale anglè. Sèvis nou an ofri plis pase 180 lang ak dyalèk. Si w bezwen asistans lang, tanpri kontakte depatman sèvis kliyantèl nou an nan (888) 400-9304 pou w ka konekte ak yon entèprèt.

Hindi

अनुवाद तथा दुभाषया सेवाओं के संबंध में सूचना

हम गैर-अंग्रेज़ी भाषी सदस्यों के लिए दुभाषया सेवा पेश करते हैं। हम 180 से अधिक भाषाओं व बोलियों में दुभाषया सेवा प्रदान करते हैं। यदि आपको भाषा संबंधी सहायता की जरूरत हो तो ककसी दुभाषये से जुडने के लिए कृपया हमारे ग्राहक सेवा षवभाग से (888) 400-9304 पर संपर्क करें।

Mon-Khmer

ដំណឹងសុគីអំពីសស្កាកម្មបកប្រែភាសាសុសស្ករ និងបកប្រែភាសាធុទាល់មាត់

យយើងឧញ្ញមានផ្តល់យវាកម្មបកប្រែភាសាដល់មោធិកន្លែងអំបូនលមិននិយាយភាសាអង់យលេ ។
យវាកម្មបកប្រែភាសាយយើងឧញ្ញ មានលបដណ្តប់យរើនជាង 180 ភាសាទូយ្វៅ និងភាសានិយាយតាមតុំបន់ ។ យបើយ្វោកអនកត្តការផ្តន្ទយបុផ្តនកបកប្រែភាសា
រួមទក់ទងបុផ្តនកបយរម្តីអតិថិជនរបយើងឧញ្ញតាមទូរ័ព្ទទយលេខ (888) 400-9304
យដើម្បីប្រឹកាបយ្វោកាន់អនកបកប្រែភាសា ។

Korean

번역 및 통역 서비스 안내

본사는 영어를 모국어로 하지 않는 회원님들께 통역 서비스를 제공합니다. 180개 이상의 언어 및 방언에 대한 통역 서비스를 이용하실 수 있습니다. 언어 지원이 필요하시다면, 고객 서비스 (888) 400-9304로 연락하시면 해당 통역사에게 연결해드립니다.

Polish
Informacja o usługach tłumaczeń pisemnych i ustnych

Członkom nieznającym języka angielskiego oferujemy usługę tłumacza ustnego. Tłumaczenia ustne są dostępne w ponad 180 językach i dialektach. Jeśli potrzebujesz pomocy językowej, skontaktuj się z naszym działem obsługi klienta pod numerem (888) 400-9304, aby połączyć się z tłumaczem ustnym.