Attachment A – Table of Enrollee Copayments, Deductibles, and Maximums
PPO Program A - Plan 4 (XX)

Group: Food Employers Labor Relations Association and United Food and Commercial Workers VEBA Fund

Contract Term: Calendar Year

Effective Date: June 1, 2021

Deductibles:	**In-Network**	**Out-of-Network**
Per Enrollee Per Contract Term	None	None
For All Family Members Per Contract Term	None	None

Maximums:	**In-Network**	**Out-of-Network**
Contract Term Maximum per Enrollee	None	None

There are no Orthodontic Services under this Plan.

Table of Enrollee Copayments

The services listed in the Table of Enrollee Copayments are considered In-Network Benefits when provided by a Dentegra PPO Provider. When provided by a Dentegra PPO Provider, We will pay the Maximum Contract Allowance less the Enrollee Copayment for covered services listed in the Table of Enrollee Copayments.

When provided by a Non-Dentegra Provider, We will pay the Maximum Contract Allowance less the Enrollee Copayment. However, Non-Dentegra Providers have no agreement with Us and are free to balance bill You for any difference between what We pay and the Submitted Fee. Non-Dentegra Providers will bill You for their normal charges, which may be higher than the Maximum Contract Allowance for the service.

All covered services are subject to *Attachment B - Limitations and Exclusions,* the EOC and Contract.

Procedures not shown are not covered. If a condition can be treated by more than one procedure only the least costly professionally adequate service will be covered.

Notice: *We reserve the right to review and amend the Table of Enrollee Copayments** annually to comply with annual Current Dental Terminology ("CDT") changes made by the American Dental Association® ("ADA").*

0100-D0999	***I. DIAGNOSTIC***	***ENROLLEE COPAYS***
D0120	Periodic oral evaluation – established patient	$0.00
D0140	Limited oral evaluation – problem focused	$0.00
D0150	Comprehensive oral evaluation – new or established patient	$0.00
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	$0.00
D0210	Intraoral – complete series of radiographic images	$0.00
D0220	Intraoral – periapical first radiographic image	$0.00
D0230	Intraoral – periapical each additional radiographic image	$0.00
D0240	Intraoral – occlusal radiographic image	$0.00
D0270	Bitewing – single radiographic image	$0.00
D0272	Bitewings – two radiographic images	$0.00
D0273	Bitewings – three radiographic images	$0.00
D0274	Bitewings – four radiographic images	$0.00
D0277	Vertical bitewings – 7 to 8 radiographic images	$0.00
D0330	Panoramic radiographic image	$0.00
D0340	2d cephalometric radiographic image – acquisition, measurement and analysis	$0.00
D0460	Pulp vitality tests	$0.00

D1000-D1999	II. PREVENTIVE	ENROLLEE COPAYS
D1110	Prophylaxis – adult	$0.00
D1120	Prophylaxis – child	$0.00
D1206	Topical application of fluoride varnish	$0.00
D1208	Topical application of fluoride	$0.00

D2000-D2999	III. RESTORATIVE	ENROLLEE COPAYS
D2140	Amalgam – one surface, primary or permanent	$0.00
D2150	Amalgam – two surfaces, primary or permanent	$0.00
D2160	Amalgam – three surfaces, primary or permanent	$0.00
D2161	Amalgam – four or more surfaces, primary or permanent	$0.00
D2330	Resin-based composite – one surface, anterior	$0.00
D2331	Resin-based composite – two surfaces, anterior	$0.00
D2332	Resin-based composite – three surfaces, anterior	$0.00
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$0.00
D2390	Resin-based composite crown, anterior	$0.00
D2940	Protective restoration	$0.00

D7000-D7999	X. ORAL AND MAXILLOFACIAL SURGERY	ENROLLEE COPAYS
D7111	Extraction, coronal remnants – primary tooth	$0.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0.00

D9000-D9999	XII. ADJUNCTIVE GENERAL SERVICES	ENROLLEECO PAYS
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$0.00
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0.00
D9999	Unspecified adjunctive procedure, by report	$10.00

Attachment B – Limitations and Exclusions

Group: Food Employers Labor Relations Association and United Food and Commercial Workers VEBA Fund

Contract Term: Calendar Year **Effective Date:** June 1, 2021

Any service that is not specifically listed as a covered dental service in *Attachment A* is excluded. In addition, the covered dental services are subject to the following exclusions and limitations:

Limitations

1. Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. Examples of Optional Services:
   - A composite restoration instead of an amalgam restoration on posterior teeth;
   - A crown where a filling would restore the tooth;
   - An inlay/onlay instead of an amalgam restoration; or
   - Porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown).

   If You receive Optional Services, an alternate benefit will be allowed, which means We will base benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.
2. We will pay for oral examinations (except after-hour exams and exams for observation) and cleanings (including periodontal cleanings in the presence of inflamed gums or any combination thereof) no more than twice in a calendar year. A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that periodontal cleanings, procedure codes that include periodontal cleanings and full mouth debridement are standardly covered as a Basic benefit, and routine cleanings are standardly covered as a Diagnostic and Preventive benefit.
3. X-ray limitations:
   - We will limit the total reimbursable amount to the provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
   - When a panoramic film is submitted with supplemental film(s), We will limit the total reimbursable amount to the provider's Accepted Fee for a complete intraoral series.
   - If a panoramic film is taken in conjunction with an intraoral complete series, We consider the panoramic film to be included in the complete series.
   - A complete intraoral series and panoramic film are each limited to once every 60 months.
   - Bitewing x-rays are limited to two times in a calendar year when provided to enrollees under age 18 and one time each calendar year for enrollees age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
4. Topical application of fluoride solutions is limited to enrollees to age 19 and no more than twice in a calendar year.

5. Space maintainer limitations:
   - Space maintainers are limited to the initial appliance and are a benefit for an enrollee to age 14.
   - Recementation of space maintainer is limited to once per lifetime.
   - The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different provider/provider's office.
6. Pulp vitality tests are allowed once per day when definitive treatment is not performed.
7. Cephalometric x-rays, oral/facial photographic images and diagnostic casts are covered once per lifetime only when orthodontic services are covered. If orthodontic services are covered, see limitations as age limits may apply.
8. Sealants are limited as follows:
   - To permanent first molars through age eight and to permanent second molars through age 15 if they are without caries (decay) or restorations on the occlusal surface.
   - Do not include repair or replacement of a sealant on any tooth within 24 months of its application.
9. Specialist consultations, screenings of patients, and assessments of patients are limited to once per lifetime per provider and count toward the oral exam frequency.
10. We will not cover replacement of an amalgam or resin-based composite restorations (fillings) or prefabricated resin and stainless steel crowns within 24 months of treatment if the service is provided by the same provider/provider office. Replacement restorations within 24 months are included in the fee for the original restoration.
11. Stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16.
12. Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
13. Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same provider/provider office within 24 months is considered part of the original procedure.
14. Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one initial visit, four interim visits and one final visit to age 19.
15. Retreatment of apical surgery by the same provider/provider office within 24 months is considered part of the original procedure.
16. Pin retention is covered not more than once in any 24-month period.
17. Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.
18. Periodontal limitations:
   - Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period.
   - Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing.
   - Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
   - If in the same quadrant, scaling and root planing must be performed at least six weeks prior to the periodontal surgery.

- Cleanings (regular and periodontal) and full mouth debridement are subject to a 30-day wait following periodontal scaling and root planing if performed by the same provider office.

19. Oral surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

20. The following oral surgery procedure is limited to age 19: transseptal fiberotomy/supra crestal fiberotomy, by report.

21. The following oral surgery procedures are limited to age 19 (or orthodontic limiting age) provided orthodontic services are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.

22. Crowns and inlays/onlays are limited to enrollees age 12 and older and are covered not more often than once in any 60-month period except when We determine the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

23. When an alternate benefit of an amalgam is allowed for inlays/ onlays, they are limited to enrollees age 12 and older and are covered not more than once in any 60-month period.

24. Core buildup, including any pins, are covered not more than once in any 60-month period.

25. Post and core services are covered not more than once in any 60-month period.

26. Crown repairs are covered not more than twice in any 60-month period.

27. Denture repairs are covered not more than once in any six-month period except for fixed denture repairs which are covered not more than twice in any 60-month period.

28. Prosthodontic appliances (including implants and/or implant supported prosthetics*) that were provided under any of Our plans will be replaced only after 60 months have passed, except when We determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to enrollees age 16 and older. Replacement of a prosthodontic appliance (and/or implant supported prosthesis*) not provided under one of Our plans will be made if We determines it is unsatisfactory and cannot be made satisfactory.

    *Applicable if implants are indicated as covered on the proposed plan design: Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Our payment for implant removal is limited to one for each implant during the enrollee's lifetime whether provided under Our or any other dental care plan.

29. When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a benefit.

30. Recementation of crowns, inlays/onlays or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same provider/provider office within six months of the initial placement. After six months, payment will be limited to one recementation in a lifetime by the same provider/provider office.

31. We limit payment for dentures to a standard partial or complete denture (enrollee coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six months after placement.

    - Denture rebase is limited to one per arch in a 24-month period and includes any relining and adjustments for six months following placement.
    - Dentures, removable partial dentures and relines include adjustments for six months following installation. After the initial six months of an adjustment or reline, adjustments are limited to two per arch in a calendar year and relining is limited to one per arch in a six-month period.
    - Tissue conditioning is limited to two per arch in a 12-month period. However, tissue conditioning is not allowed as a separate benefit when performed on the same day as a denture, reline or rebase service.

- Recementation of fixed partial dentures is limited to once in a lifetime.

Exclusions

We do not pay benefits for:

1. Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
2. Cosmetic surgery or procedures for purely cosmetic reasons.
3. Maxillofacial prosthetics.
4. Provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under).
5. Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
6. Treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or night guards/occlusal guards and abfraction.
7. Any single procedure provided prior to the date the enrollee became eligible for services under this plan.
8. Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
9. Charges for anesthesia, other than general anesthesia and IV sedation administered by a provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.
10. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
11. Laboratory processed crowns for enrollees under age 12.
12. Fixed bridges and removable partials for enrollees under age 16.
13. Interim implants.
14. Indirectly fabricated resin-based inlays/onlays.
15. Treatment by someone other than a provider or a person who by law may work under a provider's direct supervision.
16. Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments.
17. Dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
18. Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
19. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under the Contract, will be the responsibility of the enrollee and not a covered benefit.
20. Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

21. Services covered under the dental plan but exceed benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
22. Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws), unless otherwise indicated as covered on the proposed plan design.
23. Services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves and other tissues, unless otherwise indicated as covered on the proposed plan design.
24. Endodontic endosseous implant.
25. Implants and related services, unless otherwise indicated as covered on the proposed plan design.
26. Claims, bills or other demands or requests for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral.

DENTEGRA INSURANCE COMPANY'S INTERNAL APPEAL AND GRIEVANCE PROCEDURE
1130 Sanctuary Parkway
Alpharetta, GA 30009

(1) Coverage Decision: Denial of payment based upon lack of coverage of benefit under the Contract or Enrollee's eligibility status made pursuant to Title 15, Subtitle 10D of the Maryland Insurance Article that is **not** *considered an Adverse Decision under Title 15, Subtitle 10A of the Maryland Insurance Article.*

I. Definitions

A. Appeal shall mean a protest filed by an Enrollee, an Enrollee's Representative, or a Provider with Dentegra under our internal appeal process regarding a Coverage Decision concerning an Enrollee.

B. Appeal Decision shall mean a final determination by Dentegra that arises from an Appeal filed with Dentegra under our appeal process regarding a Coverage Decision concerning an Enrollee.

C. Complaint shall mean a protest filed with the Commissioner involving a Coverage Decision other than that which is covered by the complaint process for Adverse Decisions or Grievances.

D. Coverage Decision shall mean an initial determination by Dentegra that results in noncoverage of a Health Care Service; a determination by Dentegra that an Enrollee is not eligible for coverage under our health benefit plan; or any determination by Dentegra that results in the rescission of an Enrollee's coverage under a health benefit plan. Coverage Decision includes nonpayment of all or any part of a claim.

E. Health Care Service shall mean a health or medical care procedure or service rendered by a Provider that: (1) provides testing, diagnosis, or treatment of a human disease or dysfunction; or (2) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

II. Coverage Decision

A. If a post-service claim[1] is denied in whole or in part, Dentegra shall notify the Enrollee, the Enrollee's Representative, and the attending dentist of the Coverage Decision in writing within thirty (30) calendar days after the claim is filed.

B. The Coverage Decision notice will state in detail in clear, understandable language, the specific factual bases for Dentegra's decision, and include the following information:

1. That the Enrollee, the Enrollee's Representative, or a Provider acting on behalf of the Enrollee has a right to file an Appeal with us;

2. That the Enrollee, the Enrollee's Representative, or a Provider acting on behalf of the Enrollee may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves an urgent medical condition for which care has not been rendered;

3. The Commissioner's address, telephone number, and facsimile number;

[1] Dentegra does not condition receipt of a benefit, in whole or in part, upon approval of the benefit in advance of obtaining dental care. Additionally, Dentegra does not conduct concurrent review relating to continued or extended Health Care Services, or additional services for an insured undergoing a course of continued treatment.

4. That the Health Advocacy Unit is available to assist the Enrollee or the Enrollee's Representative in both mediating and filing an Appeal under Dentegra's internal appeal process; and

5. The address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

In addition:

a. The notice will include a statement that an Enrollee has the right to bring a civil action under ERISA.

b. The notice will be provided in a culturally and linguistically appropriate manner as described in the Affordable Care Act.

c. The notice will refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request).

III. Appeal

A. If the Enrollee, the Enrollee's Representative, or the attending dentist wants to file an Appeal, the Enrollee, the Enrollee's Representative, or the attending dentist must write to Dentegra within one hundred eighty (180) days after receipt of the Coverage Decision notice. In the notice, the Enrollee, the Enrollee's Representative, or attending dentist should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim should accompany the Appeal. The Enrollee, the Enrollee's Representative, or the attending dentist is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination.

B. The review of the Appeal shall be conducted on behalf of Dentegra by a person who is neither the individual who made the Coverage Decision that is the subject of the review, nor the subordinate of such individual.

C. Dentegra will render a final decision in writing to an Enrollee, an Enrollee's Representative, and a Health Care Provider acting on behalf of the Enrollee within 60 working days after the date on which the Appeal is filed.

IV. Appeal Decision

A. Within 30 calendar days after the Appeal Decision has been made, Dentegra will send to the Enrollee, the Enrollee's Representative, and the Provider a written notice of the Appeal Decision.

B. The Appeal Decision notice will state in detail in clear, understandable language the specific factual bases for Dentegra's decision; and include the following information:

1. That the Enrollee, the Enrollee's Representative, or a Provider acting on behalf of the Enrollee has a right to file a Complaint with the Commissioner within 4 months after receipt of Dentegra's Appeal Decision;

2. The Commissioner's address, telephone number, and facsimile number;

3. A statement that the Health Advocacy Unit is available to assist the Enrollee in filing a Complaint with the Commissioner; and

4. The address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

C. The notice will be provided in a culturally and linguistically appropriate manner as described in the Affordable Care Act.

D. The notice will also include that the Enrollee, the Enrollee's Representative, or attending dentist is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the Enrollee's claim for benefits. The notice shall refer to any internal rule, guideline and protocol that were relied upon (and that a copy will be provided free of charge upon request). The notice shall also state that the Enrollee has a right to bring an action under ERISA and shall state: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance agency."

E. If in the opinion of the Enrollee, the Enrollee's Representative, or attending dentist, the matter warrants further consideration, the Enrollee, the Enrollee's Representative, or the attending dentist acting on behalf of the Enrollee can immediately file a Complaint with the Commissioner or advise Dentegra in writing as soon as possible, while still retaining the right to file a Complaint with the Commissioner within 4 months of the Appeal Decision. The matter shall then be immediately referred to Dentegra's Dental Affairs Committee. This stage can include a hearing before Dentegra's Dental Affairs Committee if requested by the Enrollee, the Enrollee's Representative, or the attending dentist. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration. The notice of decision will state the specific factual bases for the decision. The decision of the Dental Affairs Committee shall be final insofar as Dentegra is concerned. Recourse thereafter would be to the Maryland Insurance Commissioner, or to the courts with an ERISA or other civil action.

(2) Denial of a covered benefit where the service is not dentally necessary, appropriate or efficient, i.e. claim benefit determinations that are considered Adverse Decisions - under Title 15, Subtitle 10A of the Maryland Insurance Article.

I. Definitions

A. Adverse Decision shall mean a utilization review determination by a Private Review Agent, a carrier, or a Health Care Provider acting on behalf of a carrier that: (1) a proposed or delivered Health Care Service covered under the Enrollee's contract is or was not medically necessary, appropriate, or efficient; and (2) may result in non-coverage of Health Care Service. An Adverse Decision does not include a decision concerning an Enrollee's status.

B. Compelling Reason shall mean to show that potential delay imposed by filing with Dentegra could result in: loss of life; serious impairment to a bodily function; serious dysfunction of a bodily organ; the Enrollee remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Enrollee to be in danger to self or others; or the Enrollee continuing to experience severe withdrawal symptoms.

C. Complaint shall mean a protest filed with the Commissioner involving an Adverse Decision or Grievance Decision concerning an Enrollee.

D. Enrollee shall mean a person entitled to health care benefits under a policy, plan, or certificate issued or delivered in Maryland by Dentegra. Unless preempted by federal law, Enrollee includes a Medicare recipient. Enrollee does not include a Medicaid recipient.

E. Enrollee's Representative shall mean a person who has been authorized by the Enrollee to file a Grievance or a Complaint on behalf of the Enrollee.

F. Filing Date shall mean the earlier of five (5) days after the date of mailing or the date of receipt.

G. Grievance shall mean a protest filed by an Enrollee, an Enrollee's Representative, or a Health Care Provider on behalf of an Enrollee with Dentegra through Dentegra's internal grievance process regarding an Adverse Decision concerning the Enrollee.

H. Grievance Decision shall mean a final determination by Dentegra that arises from a Grievance filed with Dentegra under its internal grievance process regarding an Adverse Decision concerning an Enrollee.

I. Health Advocacy Unit shall mean the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of Attorney General established under Commercial Law Article, Title 13, Subtitle 4A, Annotated Code of Maryland.

J. Health Care Provider shall mean: (1) an individual who is licensed under the Health Occupations Article to provide Health Care Services in the ordinary course of business or practice of a profession and is a treating provider of the Enrollee; or (2) a hospital, as defined in section 19-301 of the Health-General Article.

K. Health Care Service shall mean a health or medical care procedure or service rendered by a Health Care Provider including: (1) testing, diagnosis, or treatment of a human disease or dysfunction; (2) dispensing drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction; and (3) any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well-being of an individual.

L. Private Review Agent shall mean: (1) a non-hospital affiliated person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of a Maryland business entity or a third party that provides or administers hospital benefits to citizens of Maryland including a health maintenance organization, a health insurer, nonprofit health service plan, health insurance service organization, or preferred provider organization authorized to offer health insurance policies or contracts in Maryland; or (2) any person or entity including a hospital-affiliated person performing utilization review for the purpose of making claims or payment decisions on behalf of the employer's or labor union's health insurance plan under an employee assistance program for employees other than the employees employed by the hospital; or employed by a business wholly owned by the hospital.

II. Adverse Decision

A. Rendering of an Adverse Decision: When Dentegra renders an Adverse Decision[2] on all or part of a post-service claim[3], Dentegra shall:

1. Provide oral communication of the decision to the Enrollee, the Enrollee's Representative, or the attending dentist;

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[2] All Adverse Decisions i.e., decisions which are based upon whether a service was medically necessary, appropriate, or efficient, shall be made by a licensed dentist, or a panel of other appropriate Health Care Service reviewers with at least one licensed dentist on the panel.

[3] Dentegra does not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Additionally, Dentegra does not conduct concurrent review relating to continued or extended Health Care Services, or additional services for an insured undergoing a course of continued treatment.

2. Document the Adverse Decision in writing after Dentegra has provided oral communication of the decision to the Enrollee, the Enrollee's Representative, or the attending dentist.

B. Notice of Adverse Decision: Within 5 working days after the Adverse Decision has been made, Dentegra shall send a written notice to the Enrollee, the Enrollee's Representative, and the attending dentist that:

1. States in detail in clear, understandable language the specific factual bases for the carrier's decision;

2. References the specific criteria and standards, including interpretive guidelines, on which the decision was based, and may not solely use generalized terms such as "experimental procedure not covered", "service included under another procedure", or "not medically necessary"';

3. States the name, business address, and business telephone number of the designated Dentegra employee or representative who is responsible for Dentegra's internal grievance process as follows:

Manager, Professional Services
Dentegra Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809
(877) 280-4204

4. Gives written details of Dentegra's internal grievance process and procedures as follows:

If you, your Representative, or your attending dentist want the Adverse Decision reviewed, you, your Representative, or your attending dentist must contact Dentegra, either in writing or by calling Dentegra's toll-free number, 1-800-932-0783, **within one hundred eighty (180) days after receipt of the Adverse Decision.** You, your Representative, or your attending dentist should state why the claim should not have been denied. Also, any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. You, your Representative, and your attending dentist 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 denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered initially.

The review shall be conducted for Dentegra by a licensed dentist who is neither the licensed dentist who made the claim denial that is the subject of the review, nor the subordinate of such individual. The review shall be conducted by a licensed dentist, or a panel of appropriate Health Care Service reviewers with at least one dentist on the panel who is a licensed dentist. Dentegra shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry who is neither the Dentegra dental consultant who made the claim denial nor the subordinate of such dental consultant. The identity of such dental consultant is available upon request whether or not the advice was relied upon. In making the review, Dentegra will not afford deference to the initial Adverse Decision.

If after review, Dentegra continues to deny the claim, Dentegra shall notify you, your Representative, and your attending dentist in writing of the Grievance Decision within thirty (30) days of the date the Grievance is filed for a

prospective denial, and within forty-five (45) days of the date the request is received for retrospective denials. Dentegra shall send you, your Representative, and your attending dentist a notice, similar to this notice. If in the opinion of you, your Representative, or your attending dentist, the matter warrants *further* consideration, you may file an action in the courts pursuant to section 502(a) of ERISA. If you are a fully insured Enrollee, you, your Representative, or your attending dentist also have the option to file a Complaint with the Maryland Insurance Administration within four (4) months after receipt of Dentegra's Grievance Decision. A Complaint may be filed without first filing a Grievance if: (1) Dentegra has waived the requirement that its internal grievance process be exhausted; (2) Dentegra failed to comply with any of the requirements of the internal grievance process; or (3) You, your Representative, or your attending dentist can demonstrate a Compelling Reason to do so as determined by the Maryland Insurance Administration.

5. Includes the following information:

   a. That, if the Enrollee is fully insured, the Enrollee, the Enrollee's Representative, or attending dentist has a right to file a Complaint with the Commissioner within four (4) months after receipt of Dentegra's Grievance Decision;

   b. That a Complaint may be filed without first filing a Grievance if the Enrollee, the Enrollee's Representative, or a Health Care Provider filing a Grievance on behalf of the Enrollee can demonstrate a Compelling Reason to do so as determined by the Commissioner;

   c. The address, telephone number, and facsimile number of the Commissioner:

      Maryland Insurance Administration
      Attn: Consumer Complaint Investigation
      Life and Health/Appeals and Grievance
      200 St. Paul Place, Suite 2700
      Baltimore, MD 21202
      Phone: 1-800-492-6116 or 410-468-2000
      TTY: 1-800-735-2258
      Fax: 410-468-2270 or 410-468-2260

   d. The Health Advocacy Unit is available to assist the Enrollee or the Enrollee's Representative in both mediating and filing a Complaint with the Commissioner;

   e. The address, telephone number, facsimile number, and email address of the Health Advocacy Unit of Maryland's Consumer Protection Division:

      Office of the Attorney General
      200 St. Paul Place, 16th Floor
      Baltimore, MD 21202
      Phone: 410-528-1840
      Toll Free: 877-261-8807
      TTY: 1-800-576-6372
      Fax: 410-576-6571
      Email: heau@oag.state.md.us]

III. Internal Grievance Procedure

A. Informal Inquiry Option: If a claim is denied in whole or in part, an Enrollee, an Enrollee's Representative, or his or her attending dentist may make an informal inquiry regarding general program, eligibility questions and Adverse Decisions by contacting Dentegra via its toll-free number at 1-800-932-0783. Every caller has access to a supervisor if dissatisfied with the response.

B. Non-emergency Appeals of Adverse Decisions: In lieu of making an informal inquiry, an Enrollee, an Enrollee's Representative, or his or her attending dentist may choose to Appeal the Adverse Decision. The Enrollee, Enrollee's Representative or Health Care Provider may do so within one hundred eighty (180) days after receipt of the Adverse Decision, either by writing to Dentegra or by calling Dentegra at its toll-free number. Written acknowledgement of the filing of the Appeal to the appealing party will be provided to the Enrollee, the Enrollee's Representative, or the attending dentist within five (5) days of the filing of the Appeal. The letter or oral request for Appeal should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. The Enrollee, the Enrollee's Representative, or the attending dentist 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 denied claim.

C. Notification of Information Necessary to Conduct the Internal Grievance Process: If Dentegra requires information necessary to conduct the internal grievance process, Dentegra shall notify the Enrollee, the Enrollee's Representative, or the attending dentist, in writing within five (5) working days of receipt of the Appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, Dentegra shall request the missing information, in writing, within five (5) working days of receipt of the partial information. Dentegra will assist the Enrollee, the Enrollee's Representative, or the Health Care Provider in gathering the necessary information without further delay.

D. The Review: The review shall be conducted for Dentegra by a dental consultant who is neither the dental consultant who made the claim denial that is the subject of the review, nor the subordinate of such individual. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination. The review shall be conducted by a licensed dentist, or a panel of appropriate Health Care Service reviewers with at least one dentist on the panel who is a licensed dentist. Dentegra shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Dentegra dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Dentegra dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available on request. In making the review, Dentegra will not afford deference to the initial Adverse Decision. A clinical examination at Dentegra's cost may be implemented, along with discussion among dentist consultants. At this point, the Enrollee may also request a hearing.

E. Grievance Decision: For prospective denials, Dentegra shall make a Grievance Decision within thirty (30) days of the date the Grievance is filed. For retrospective denials, Dentegra shall make a Grievance Decision within forty-five (45) days of the date the Grievance is filed. However, Dentegra may extend these periods with the written consent of the Enrollee, the Enrollee's Representative, or the attending dentist who filed the Grievance on behalf of the Enrollee, for a period of no longer than thirty (30) working days. Dentegra shall document the Grievance Decision in writing after Dentegra has provided oral communication of the decision to the Enrollee, the

Enrollee's Representative, and the attending dentist. Within five (5) days after the Grievance Decision has been made, Dentegra shall send a written notice to the Enrollee, the Enrollee's Representative, or the attending dentist in accordance with Section IV below. The Grievance Decision shall be final insofar as Dentegra is concerned. Recourse thereafter would be to the courts with an ERISA or other civil action, or to the Maryland Insurance Administration.

F. Complaints: An Enrollee, an Enrollee's Representative, or the attending dentist has a right to file a Complaint with the Commissioner within four (4) months after receipt of Dentegra's Grievance Decision. When filing a Complaint with the Commissioner, the Enrollee or the Enrollee's Representative will be required to authorize the release of any medical records of the Enrollee that may be required to be reviewed for the purpose of reaching a decision on the Complaint.

IV. Distribution of Information to Enrollees/Enrollees' Representatives/Attending Dentists Upon Entry of Grievance Decision. The paragraphs below outline the contents of the Notification of Grievance Decision.

A. Content and Notification of Grievance Decision. If after the claim is reviewed, Dentegra continues to deny the claim, Dentegra shall send the Enrollee, the Enrollee's Representative, and the attending dentist a notice, which contains:

1. A clear statement in understandable language containing the specific factual basis for Dentegra's decision;

2. A clear statement that the notice constitutes Dentegra's final Grievance Decision;

3. Reference to the specific criteria and standards, including interpretive guidelines, on which the decision was based (without using only generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary");

4. The name, business address, and business telephone number of the designated employee or Dentegra representative who has responsibility for Dentegra's internal grievance process as follows:

   Manager, Professional Services
   Dentegra Insurance Company
   P.O. Box 1809
   Alpharetta, GA 30023-1809
   (877) 280-4204

5. A statement that a fully insured Enrollee, Enrollee's Representative, or Health Care Provider who has filed the Grievance on behalf of a fully insured Enrollee, has a right to file a Complaint with the Commissioner within four (4) months after receipt of Dentegra's Grievance Decision;

6. The Commissioner's address, telephone number and facsimile number as follows:

   Maryland Insurance Administration
   Attn: Consumer Complaint Investigation
   Life and Health/Appeals and Grievance
   200 St. Paul Place, Suite 2700
   Baltimore, MD 21202
   Phone:1-800-492-6116 or 410-468-2000
   TTY: 1-800-735-2258
   Fax: 410-468-2270 or 410-468-2260

7. A statement that the Health Advocacy Unit is available to assist the Enrollee or the Enrollee's Representative in filing a Complaint with the Commissioner;

8. The address, telephone number, facsimile number, and email address of the Health Advocacy Unit of Maryland's Consumer Protection Division as follows:

Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840
Toll Free: 877-261-8807
TTY: 1-800-576-6372
Fax: 410-576-6571
Email: heau@oag.state.md.us

9. Notices will be provided in a culturally and linguistically appropriate manner as described in the Affordable Care Act.

Michael G. Hankinson, Esq.
Executive Vice President, Chief Legal Officer

HIPAA Notice of Privacy Practices

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

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

This notice is required by law to inform you of how Dentegra and its affiliates ("Dentegra") protect the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as individually identifiable information regarding a patient's health care history, mental or physical condition or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Dentegra receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We follow the privacy practices described in this notice and federal and state privacy requirements that apply to our administration of your benefits. Dentegra reserves the right to change our privacy practice effective for all PHI maintained. We will update this notice if there are material changes and redistribute it to you within 60 days of the change to our practices. We will also promptly post a revised notice on our website. A copy may be requested anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Dentegra program and will be informed on how to obtain a copy at least every three years.

PERMITTED USES AND DISCLOSURES OF YOUR PHI

Uses and disclosures of your PHI for treatment, payment or health care operations
Your explicit authorization is not required to disclose information about yourself for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or plan sponsor to administer your benefits. As permitted by law, we may disclose PHI to third-party affiliates that perform services for Dentegra to administer your benefits, and who have signed a contract agreeing to protect the confidentiality of your PHI, and have implemented privacy policies and procedures that comply with applicable federal and state law.

Some examples of disclosure and use for treatment, payment or operations include: processing your claims, collecting enrollment information and premiums, reviewing the quality of health

care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Some other examples are:

- Uses and/or disclosures of PHI in facilitating treatment. *For example, Dentegra may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment. *For example, Dentegra may use and disclose your PHI to bill you or your plan sponsor.*
- Uses and/or disclosures of PHI for health care operations. *For example, Dentegra may use and disclose your PHI to review the quality of care provided by our network of providers.*

Other permitted uses and disclosures without an authorization

We are permitted to disclose your PHI upon your request, or to your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with the law, and when otherwise required by law. Dentegra may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Some other examples include: to notify or assist in notifying a family member, another person, or a personal representative of your condition; to assist in disaster relief efforts; to report victims of abuse, neglect or domestic violence to appropriate authorities; for organ donation purposes; to avert a serious threat to health or safety; for specialized government functions such as military and veterans activities; for workers' compensation purposes; and, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting, provided it does not contain genetic information. Information can also be de-identified or summarized so it cannot be traced to you and, in selected instances, for research purposes with the proper oversight.

Disclosures Dentegra makes with your authorization

Dentegra will not use or disclose your PHI without your prior written authorization unless permitted by law. If you grant an authorization, you can later revoke that authorization, in writing, to stop the future use and disclosure. The authorization will be obtained from you by Dentegra or by a person requesting your PHI from Dentegra.

YOUR RIGHTS REGARDING PHI

You have the right to request an inspection of and obtain a copy of your PHI.
You may access your PHI by contacting Dentegra at the address at the bottom of this notice. You must include (1) your name, address, telephone number and identification number, and (2) the PHI you are requesting. Dentegra may charge a reasonable fee for providing you copies of your PHI. Dentegra will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or x-rays, is returned by Dentegra to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Dentegra does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact Dentegra as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI.
You have the right to ask that we limit how we use and disclose your PHI, however, you may not restrict our legal or permitted uses and disclosures of PHI. While we will consider your request, we are not legally required to accept those requests that we cannot reasonably implement or comply with during an emergency. If we accept your request, we will put our understanding in writing.

You have the right to correct or update your PHI.
You may request to make an amendment of PHI we maintain about you. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have rights related to the use and disclosure of your PHI for marketing.
Dentegra agrees to obtain your authorization for the use or disclosure of PHI for marketing when required by law. You have the opportunity to opt-out of marketing that is permitted by law without an authorization. Dentegra does not use your PHI for fundraising purposes.

You have the right to request or receive confidential communications from us by alternative means or at a different address.
Alternate or confidential communication is available if disclosure of your PHI to the address on file could endanger you. You may be required to provide us with a statement of possible danger,

as well as specify a different address or another method of contact. Please make this request in writing to the address noted at the end of this notice.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons, certain law enforcement purposes or disclosures made as part of a limited data set. Please contact us at the number at the end of this notice if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by email.

A copy of this notice is posted on the Dentegra website. You may also request an email copy or paper copy of this notice by calling our Customer Service number listed at the bottom of this notice.

You have the right to be notified following a breach of unsecured protected health information.

Dentegra will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

COMPLAINTS

You may file a complaint with Dentegra and/or with the U. S. Secretary of Health and Human Services if you believe Dentegra has violated your privacy rights. Complaints to Dentegra may be filed by notifying the contact below. We will not retaliate against you for filing a complaint.

Contacts

You may contact Dentegra at 877-280-4204, or you may write to the address listed below for further information about the complaint process or any of the information contained in this notice.

Dentegra Insurance Company
P.O. Box 1850
Alpharetta, GA 30023-1850

This notice is effective on and after January 1, 2017.

Note: Dentegra's privacy practices reflect applicable federal law as well as known state law and regulations. If applicable state law is more protective of information than the federal privacy laws, Dentegra protects information in accordance with the state law.

Last Significant Changes to this notice:

- Clarified that Dentegra does not use your PHI for fundraising purposes. Effective January 1, 2016
- Clarified that Dentegra's privacy policy reflect federal and state requirements. – effective January 1, 2015
- Updated contact information (mailing address and phone number) – effective July 1, 2013
- Updated Dentegra's duty to notify affected individuals if a breach of their unsecured PHI occurs – effective July 1, 2013
- Clarified that Dentegra does not and will not sell your information without your express written authorization – effective July 1, 2013
- Clarified several instances where the law requires individual authorization to use and disclose information (e.g., fundraising and marketing as noted above) – effective July 1, 2013