

UNITED CONCORDIA

UNITED CONCORDIA

4401 Deer Path Road
Harrisburg, PA 17110

Dental Plan Certificate of Insurance

Network Plan

STATE OF MARYLAND PPO
842843000, 842843001, 842843002, 842843004,
842843006, 842843007, 842843008, 842843009
JULY 1, 2011

In AL, United Concordia is underwritten by
United Concordia Dental Corporation of Alabama

In AK, AR, AZ, CA, CO, CT, FL, GA, HI, IA, ID, IN, KS, LA, MA, MD, ME, MN, MI, MS,
MT, NE, NV, NH, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WV, WY,
United Concordia is underwritten by
United Concordia Insurance Company

In DE, DC, IL, KY, MD, MO, NC, NJ, PA, United Concordia is underwritten by
United Concordia Life and Health Insurance Company

In NY, United Concordia is underwritten by
United Concordia Insurance Company of New York

**Notice to Florida residents: The benefits of the policy providing your
coverage are governed by a state other than Florida.**

CERTIFICATE OF INSURANCE

INTRODUCTION

This Certificate of Insurance provides information about Your dental coverage. Read it carefully and keep it in a safe place with Your other valuable documents. Review it to become familiar with Your benefits and when You have a specific question regarding Your coverage.

To offer these benefits, Your Group has entered into a Group Policy of insurance with United Concordia. The benefits are available to You as long as the Premium for You and any enrolled Dependents is paid and obligations under the Group Policy are satisfied. In the event of conflict between this Certificate and the Group Policy, the Group Policy will rule. This Certificate is not a summary plan description under the Employee Retirement Income Security Act (ERISA).

If You have any questions about Your coverage or benefits, please call our Customer Service Department toll-free at:

(888) 638-3384

For general information, Participating Dentist or benefit information, You may also log on to our website at:

www.unitedconcordia.com

Claim forms should be sent to:

United Concordia Companies, Inc.
Dental Claims
PO Box 69421
Harrisburg, PA 17106-9421

TABLE OF CONTENTS

DEFINITIONS.....	3
ELIGIBILITY AND ENROLLMENT.....	5
HOW THE DENTAL PLAN WORKS.....	6
BENEFITS.....	7
TERMINATION.....	11
CONTINUATION OF COVERAGE.....	12
GENERAL PROVISIONS.....	12

Attached:

Appeal Procedure Addendum
State Law Provisions Addendum
Schedule of Benefits
Schedule of Exclusions and Limitations

DEFINITIONS

Certain terms used throughout this Certificate begin with capital letters. When these terms are capitalized, use the following definitions to understand their meanings as they pertain to Your benefits and the way the dental plan works.

Certificate Holder(s) - An individual who has enrolled him/herself and his/her Dependents for dental coverage and for whom Premium payments are due and payable. Also referred to as "You" or "Your" or "Yourself".

Certificate of Insurance ("Certificate") - This document, including riders, schedules, addenda and/or endorsements, if any, which describes the coverage purchased from the Company by the Policyholder.

Coinsurance - Those remaining percentages or dollar amounts of the Maximum Allowable Charge for a Covered Service that are the responsibility of either the Certificate Holder or his/her enrolled Dependents after the Plan pays the percentages or dollar amounts shown on the Schedule of Benefits for a Covered Service.

Company - United Concordia, the insurer. Also referred to as "We", "Our" or "Us".

Coordination of Benefits ("COB") - A method of determining benefits for Covered Services when the Member is covered under more than one plan to prevent duplication of payment so that no more than the incurred expense is paid.

Cosmetic - Those procedures which are undertaken primarily to improve or otherwise modify the Member's appearance.

Covered Service(s) - A service or supply specified in this Certificate and the Schedule of Benefits for which benefits will be covered subject to the Schedule of Exclusions and Limitations, when rendered by a dentist, or any other duly licensed dental practitioner under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

Deductible(s) - A specified amount of expenses set forth in the Schedule of Benefits for Covered Services that must be paid by the Member before the Company will pay any benefit.

Dentally Necessary - A dental service or procedure is determined by a dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the dentist and the prevailing standards of care in the professional community. The determination will be made by the dentist in accordance with guidelines established by the Company. When there is a conflict of opinion between the dentist and the Company on whether or not a dental service or procedure is Dentally Necessary, the opinion of the Company will be final.

Dependent(s) - Certificate Holder's spouse or domestic life partner as defined by the Policyholder and/or state law and any unmarried child or stepchild of a Certificate Holder or unmarried member of the Certificate Holder's household resulting from a court order or placement by an administrative agency, enrolled in the Plan:

- (a) until the end of the month which he/she reaches age 25; or
- (b) until the end of the month which he/she reaches age 25 if he/she is a full-time student at an accredited educational institution and chiefly reliant upon the Certificate Holder for maintenance and support; or
- (c) to any age if he/she is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

Effective Date - The date on which the Group Policy begins or coverage of enrolled Members begins.

Exclusion(s) - Services, supplies or charges that are not covered under the Group Policy as stated in the Schedule of Exclusions and Limitations.

Experimental or Investigative - The use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Company, determines is not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which was not granted at the time the services were rendered. The Company will rely on the advice of the general dental community including, but not limited to dental consultants, dental journals and/or governmental regulations, to make this determination.

Grace Period - A period of no less than 31 days after Premium payment is due under the Policy, in which the Policyholder may make such payment and during which the protection of the Group Policy continues, subject to payment of Premium by the end of the Grace Period.

Group Policy - The agreement between the Company and the Policyholder, under which the Certificate Holder is eligible to enroll.

Limitation(s) - The maximum frequency or age limit applied to a Covered Service set forth in the Schedule of Exclusions and Limitations incorporated by reference into this Certificate.

Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during a specified period as shown on the Schedule of Benefits.

Maximum Allowable Charge - The maximum amount the Plan will allow for a specific Covered Service. Maximum Allowable Charges may vary depending upon the contract between the Company and the particular Participating Dentist rendering the service. Depending upon the Plan purchased by the Policyholder, Maximum Allowable Charges for Covered Services rendered by Non-Participating Dentists may be the same or higher than such charges for Covered Services rendered by Participating Dentists in order to help limit out-of-pocket costs of Members choosing Non-Participating Dentists.

Member(s) - Certificate Holder(s) and their Dependent(s).

Non-Participating Dentist - A dentist who has not signed a contract with the Company or an affiliate of the Company.

Participating Dentist - A dentist who has executed a Participating Dentist Agreement with the Company or an affiliate of the Company, under which he/she agrees to accept the Company's Maximum Allowable Charges as payment in full for Covered Services.

Plan - Dental benefits pursuant to this Certificate and attached Schedule of Exclusions and Limitations and Schedule of Benefits.

Policyholder - Organization that executes the Group Policy. Also referred to as "Your Group".

Premium - Payment that the Policyholder must remit to the Company in exchange for coverage of the Policyholder's Members.

Renewal Date - The date on which the Group Policy renews. Also known as anniversary date.

Schedule of Benefits - Attached summary of Covered Services, Plan payment percentages, Deductibles, Waiting Periods and Maximums applicable to benefits payable under the Plan.

Schedule of Exclusions and Limitations - Attached list of Exclusions and Limitations applicable to benefits, services, supplies or charges under the Plan.

State Law Provisions Addendum - Attached document containing specific provisions required by state law to be modified, deleted from, and/or added to the Certificate of Insurance.

Termination Date - The date on which the dental coverage ends for a Member or the Group Policy terminates.

Waiting Period(s) - A period of time a Member must be enrolled under the Group Policy before benefits will be paid for Covered Services as shown on the attached Schedule of Benefits.

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

If You have already satisfied Your Group's eligibility requirements when the Group Policy begins and Your enrollment information is supplied to Us, Your coverage and Your Dependents' coverage will begin on the Effective Date of the Group Policy provided We receive the Premium.

If You join the Group or become employed after the initial Effective Date of the Group Policy, in order to be eligible to enroll, You must first satisfy any eligibility requirements of Your Group. Your Group will inform You of these requirements.

You must supply the required enrollment information on Yourself and Your Dependents within 60 days of the date You meet these requirements. Your Dependents must also meet the requirements detailed in the definition of Dependent in the Definitions section of this Certificate.

Your coverage and Your Dependents' coverage will begin on the date specified in the enrollment information supplied to Us provided Premium is paid.

The Company is not liable to pay benefits for any services started prior to a Member's Effective Date of coverage. Multi-visit procedures are considered "started" when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. Procedures started prior to the Member's Effective Date are the liability of the Member or a prior insurance carrier.

Enrollment Changes

After Your initial enrollment, there are certain life change events that permit You to add Dependents. These events are:

- birth
- adoption
- court order of placement or custody
- change in student status for a child
- marriage.

To enroll a new Dependent as a result of one of these events, You must notify Your Group and supply the required enrollment change information within 60 days of the date You acquired the Dependent. The Dependent must meet the requirements detailed in the definition of Dependent in the Definitions section of this Certificate.

Except for newly born or adoptive children, coverage for the new Dependent will begin on the date specified in the enrollment information provided to Us as long as the Premium is paid.

Newly born children of a Member will be considered enrolled from the moment of birth. Adoptive children will be considered enrolled from the date of adoption or placement, except for those adopted or placed within 60 days of birth who will be considered enrolled Dependents from the moment of birth. In order for coverage of newly born or adoptive children to continue beyond the first 60 day period, the child's enrollment information must be provided to Us and the required Premium must be paid within the 60 day period.

For an enrolled Dependent child who is mentally or physically handicapped, evidence of his/her reliance on You for maintenance and support due to his/her condition must also be supplied to Us within 30 days after said Dependent attains the limiting age shown in the definition of Dependent. If the Dependent is a full-time student at an accredited educational institution, the evidence must be provided within 30 days after the Dependent attains the limiting age for students. Such evidence will be requested based on information provided by the Member's physician but no more frequently than annually.

Dependent coverage may only be terminated when certain life change events occur including death, divorce or reaching the limiting age or during open enrollment periods.

Late Enrollment

If You or Your Dependents are not enrolled within 60 days of initial eligibility or a life change event, You or Your Dependents cannot enroll until the next open enrollment period conducted for Your Group or unless otherwise specified in any applicable Late Entrant Rider to the Certificate of Insurance. If You are required to provide coverage for a Dependent child pursuant to a court order, You will be permitted to enroll the Dependent child without regard to enrollment season restrictions.

HOW THE DENTAL PLAN WORKS

Choice of Provider

You may choose any licensed dentist for services. However, Your out-of-pocket costs will vary depending upon whether or not Your dentist participates with United Concordia. If You choose a Participating Dentist, You may limit Your out-of-pocket cost. Participating Dentists agree by contract to accept Maximum Allowable Charges as payment in full for Covered Services. Participating dentists also complete and send claims directly to Us for processing. To find a Participating Dentist, visit *Find a Dentist* on Our website at www.unitedconcordia.com click on client's corner, then State of Maryland or call Our Interactive Voice Response System at the toll-free number in the Introduction section of this Certificate.

If You go to a dentist who is not a United Concordia Participating Dentist, You may have to pay the dentist at the time of service, complete and submit Your own claims and wait for Us to reimburse You. You will be responsible for the dentist's full charge which may result in higher out-of-pocket costs for You.

When You visit the dental office, let Your dentist know that You are covered under a United Concordia program and give the dental office Your contract ID number and group number. If Your dentist has questions about Your eligibility or benefits, instruct the office to call Our Interactive Voice Response System at the toll-free number in the Introduction section of this Certificate or visit *My Patients' Benefits* on Our website at www.unitedconcordia.com click on client's corner, then State of Maryland.

Claims Submission

Upon completion of treatment, the services performed must be reported to Us in order for You to receive benefits. This is done through submission of a paper claim or electronically. Participating Dentists will report services to Us directly for You and Your Dependents.

Most dental offices submit claims or report services for patients. However, if You do not receive treatment from a Participating Dentist, You may have to complete and send claims to Us in the event the dental office will not do this for You. To obtain a claim form, visit the Members link on our website at www.unitedconcordia.com click on client's corner, then State of Maryland. Be sure to include on the claim:

- the patient's name
- date of birth
- Your contract ID number
- patient's relationship to You
- Your name and address
- the name and policy number of a second insurer if the patient is covered by another dental plan.

Your dentist should complete the treatment and provider information or supply an itemized receipt for You to attach to the claim form. Send the claim form or predetermination to the address in the Introduction section of this Certificate.

For orthodontic treatment, if covered under the Plan, an explanation of the planned treatment must be submitted to Us. Upon review of the information, We will notify You and Your dentist of the reimbursement schedule, frequency of payment over the course of the treatment, and Your share of the cost.

Should You have any questions concerning Your coverage, eligibility or a specific claim, contact Us at the address and telephone number in the Introduction section of this Certificate or log onto *My Dental Benefits* at www.unitedconcordia.com click on client's corner, then State of Maryland.

Predetermination

A predetermination is a review in advance of treatment by Us to determine patient eligibility and coverage for planned services. Predetermination is not required to receive a benefit for any service under the Plan. However, it is recommended for extensive, more costly treatment such as crowns and bridges. A predetermination gives You and Your dentist an estimate of Your coverage and how much Your share of the cost will be for the treatment being considered.

To have services predetermined, You or Your dentist should submit a claim showing the planned procedures but leaving out the dates of services. Be sure to sign the predetermination request. Substantiating material such as radiographs and periodontal charting may be requested by Us to estimate benefits and coverage. We will determine benefits payable, taking into account Exclusions and Limitations including alternate treatment options based upon the provisions of the Plan. We will notify you of the estimated benefits.

When the services are performed, simply have Your dentist call Our Interactive Voice Response System at the telephone number in the Introduction section of this Certificate, or fill in the dates of service for the completed procedures on the predetermination notification and re-submit it to Us for processing. Any predetermination amount estimated is subject to continued eligibility of the patient. We may also make adjustments at the time of final payment to correct any mathematical errors, apply coordination of benefits, and comply with Your Plan in effect and remaining program Maximum dollars on the date of service.

BENEFITS

Schedule of Benefits

Your benefits are shown on the attached Schedule of Benefits. The Schedule of Benefits shows:

- the classes and groupings of dental services covered, shown with a "Plan Pays" percentage greater than "0%".
- the percentage of the Maximum Allowable Charges the Plan will pay.
- any Waiting Periods that must be satisfied for particular services before the Plan will pay benefits. Waiting Periods are measured from date of enrollment in the Plan.
- any Deductibles You and/or Your family must pay before any benefits for Covered Services will be paid by the Plan, and the Covered Services for which there is no deductible. The Deductible is applied only to expenses for Covered Services and on either a calendar year or contract year basis (yearly period beginning with the Effective Date of the Group Policy).
- any Maximums for Covered Services for a given period of time; for example, annual for most services and lifetime for orthodontics. Annual Maximums are applied on either a calendar or contract year basis.

Your Out-of-Pocket Costs

In order to keep the Plan affordable for You and Your Group, the Plan includes certain cost-sharing features. If the class or service grouping is not covered under the Plan, the Schedule of Benefits will indicate either “not covered” or “Plan Pays -- 0%”. You will be responsible to pay Your dentist the full charge for these uncovered services.

Classes or service groupings shown with “Plan Pays” percentages greater than 0% but less than 100% require you to pay a portion of the cost for the Covered Service. For example, if the Plan pays 80%, Your share or Coinsurance is 20% of the Maximum Allowable Charge. You are also responsible to pay any Deductibles, charges exceeding the Plan Maximums or charges for Covered Services performed before satisfaction of any applicable Waiting Periods.

Services

The general descriptions below explain the services on the Schedule of Benefits. The descriptions are not all-inclusive – they include only the most common dental procedures in a class or service grouping. Specific dental procedures may be shifted among groupings or classes or may not be covered depending on Your Group’s choice of Plan. Check the Schedule of Benefits attached to this Certificate to see which groupings are covered (“Plan Pays percentage greater than “0%”). Also, have Your provider call Us to verify coverage of specific dental procedures or log on to *My Dental Benefits* or *My Patients’ Benefits* at www.unitedconcordia.com to check coverage. Services covered on the Schedule of Benefits are also subject to Exclusions and Limitations. Be sure to review the Schedule of Exclusions and Limitations also attached to this Certificate.

- Exams and X-rays for diagnosis – oral evaluations, bitewings, periapical and full-mouth x-rays
- Cleanings, Fluoride Treatments, Sealants for prevention
- Palliative Treatment for relief of pain for dental emergencies
- Space Maintainers to prevent tooth movement
- Basic Restorative to treat caries (cavities, tooth decay) – amalgam and composite resin fillings, stainless steel crowns, crown build-ups and posts and cores
- Endodontics to treat the dental pulp, pulp chamber and root canal – root canal treatment and retreatment, pulpotomy, pulpal therapy, apicoectomy, and apexification
- Non-surgical Periodontics for non-surgical treatment of diseases of the gums and bones supporting the teeth – periodontal scaling and root planing, periodontal maintenance
- Repairs of Crowns, Inlays, Onlays, Bridges, Dentures – repair, recementation, re-lining, re-basing and adjustment
- Simple Extractions – non-surgical removal of teeth and roots
- Surgical Periodontics for surgical treatment of the tissues supporting and surrounding the teeth (gums and bone) – gingivectomy, gingivoplasty, gingival curettage, osseous surgery, crown lengthening, bone and tissue replacement grafts
- Complex Oral Surgery for surgical treatment of the hard and soft tissues of the mouth – surgical extractions, impactions, excisions, exposure, root removal, alveoplasty and vestibuloplasty
- Anesthesia for elimination of pain during treatment – general or nitrous oxide or IV sedation
- Inlays, Onlays, Crowns when the teeth cannot be restored by fillings
- Prosthetics – fixed bridges, partial and complete dentures
- Orthodontics for treatment of poor alignment and occlusion – diagnostic x-rays, active treatment and retention for eligible dependent children

Exclusions and Limitations

Services indicated as covered on the Schedule of Benefits are subject to frequency or age Limitations detailed on the attached Schedule of Exclusions and Limitations. The existence of a Limitation on the Schedule of Exclusions and Limitations does not mean the service is covered under the Plan. Before reviewing the Limitations, You must first check the Schedule of Benefits to see which services are covered. No benefits will be provided for services, supplies or charges detailed under the Exclusions on the Schedule of Exclusions and Limitations.

Payment of Benefits

If You have treatment performed by a Participating Dentist, We will pay covered benefits directly to the Participating Dentist. Both You and the dentist will be notified of benefits covered, Plan payment and any amounts You owe for Coinsurance, Deductibles, charges exceeding Maximums or charges for services not covered. Payment will be based on the Maximum Allowable Charge the treating Participating Dentist has contracted to accept.

If You receive treatment from a Non-Participating Dentist, We will send payment for covered benefits to You unless You indicate on the claim that You wish payment to be sent directly to Your treating dentist. You will be notified of the services covered, Plan payment and any amounts You owe for Coinsurance, Deductibles, charges exceeding Maximums or charges for services not covered. The Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the dentist any difference between the Plan's payment and the dentist's full charge for the services.

The Company does not disclose claim or eligibility records except as allowed or required by law and then in accordance with federal and state law. The Company maintains physical, electronic, and procedural safeguards to guard claims and eligibility information from unauthorized access, use, and disclosure.

Overpayments

When We make an overpayment for benefits, We have the right to recover the overpayment either from You, from the person to whom it was paid, or from the dentist to whom the payment was made on behalf of the Member. We will recover the overpayment either by requesting a refund or offsetting the amount overpaid from future claim payments. Recovery will be done in accordance with any applicable state laws or regulations.

Coordination of Benefits (COB)

If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, benefits will be coordinated. This means that one plan will be primary and determine its benefits before those of the other plan and without considering the other plan's benefits. The other plan will be secondary and determine its benefits after the primary plan. The secondary plan's benefits may be reduced because of the primary plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this Plan will determine payment.

1. The following words and phrases regarding the Coordination of Benefits ("COB") provision are defined as set forth below:
 - A) **Allowable Amount** is the Plan's allowance for items of expense, when the care is covered at least in part by one or more Plans covering the Member for whom the claim is made.
 - B) **Claim Determination Period** means a benefit year. However, it does not include any part of a year during which a person has no coverage under this Plan.
 - C) **Other Dental Plan** is any form of coverage which is separate from this Plan with which coordination is allowed. **Other Dental Plan** will be any of the following which provides dental benefits, or services, for the following: Group insurance or group type coverage, whether insured or uninsured. It also includes coverage other than school accident type coverage (including grammar, high school and college student coverages) for accidents only, including athletic injury, either on a twenty-four (24) hour basis or on a "to and from school basis," or group or group type hospital indemnity benefits of \$100 per day or less.
 - D) **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.
 - E) **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.

- F) **Plan** means this document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.
2. The fair value of services provided by the Company will be considered to be the amount of benefits paid by the Company. The Company will be fully discharged from liability to the extent of such payment under this provision.
 3. In order to determine which plan is primary, this Plan will use the following rules.
 - A) If the other plan does not have a provision similar to this one, then that plan will be primary.
 - B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.
 - C) Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:
 - 1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
 - 2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
 - 3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
 - 4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
 - D) Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - 1) First, the plan of the parent with custody of the child.
 - 2) Then, the plan of the spouse of the parent with the custody of the child; and
 - 3) Finally, the plan of the parent not having custody of the child.
 - 4) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
 - 5) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 3-C) above, titled Dependent Child/Parents Not Separated or Divorced.
 - E) Active/Inactive Member
 - 1) For actively employed Members and their spouses over the age of 65 who are covered by Medicare, the plan will be primary.
 - 2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.
 - F) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary.
 - G) The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a Member or a Dependent.
 4. Right to Receive and Release Needed Information -- Certain facts are needed to apply these COB rules. The Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Any health information furnished to a third party will be released in accordance with federal law. Each person claiming benefits under This Plan must give any facts needed to pay the claim.

5. Facility of Payment -- A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Company may pay the amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan, and the Company will not pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the services prepaid by the Company.
6. Right of Recovery -- If the payment made by the Company is more than it should have paid under this COB provision, the Company may recover the excess from one or more of the following: (1) persons it has paid or for whom it has paid; or (2) insurance companies; or (3) other organization. Members are required to assist the Company to implement this section.

Workers' Compensation

When a Member is eligible for Workers' Compensation benefits through employment, the cost of dental treatment for an injury which arises out of and in the course of Member's employment is not a covered benefit under this Plan. Therefore, if the Company pays benefits which are covered by a Workers' Compensation policy, the Company has the right to obtain reimbursement for those benefits paid. The Member must provide any assistance necessary, including furnishing information and signing necessary documents, for the Company to receive the reimbursement.

Review of a Benefit Determination

If You are not satisfied with the Plan's benefit, please contact Our Customer Service Department at the toll-free telephone number in the Introduction section of this Certificate. If, after speaking with a Customer Service representative, You are still dissatisfied, refer to the Appeal Procedure Addendum attached to this Certificate for further steps You can take regarding Your claim.

TERMINATION -- WHEN COVERAGE ENDS

Your coverage and/or Your Dependents' coverage will end:

- on the date You lose eligibility under Your Group's eligibility requirements; or
- on the date Premium payment ceases for You and/or Your Dependents, as specified by your Group; or
- on the date Your Dependent(s) cease to meet the requirements in the definition of Dependent in the Definitions section of this Certificate;

If Your coverage or Your Dependents' coverage is terminated as described above, coverage for completion of a dental procedure requiring two or more visits on separate days will be extended for a period of 90 days after the Member's Termination Date in order for the procedure to be finished. The procedure must be started prior to the Member's Termination Date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Member's Termination Date.

If Your coverage ends, Your Dependents' coverage will end on the same date unless otherwise specified in a State Law Provisions Addendum to this Certificate. If the Group Policy is cancelled, Your coverage and Your Dependents' coverage will end on the Group Policy Termination Date.

In the event of a default in Premium payment by the Policyholder, coverage will remain in effect for the Grace Period extended for payment of the overdue Premium. If the Premium is not received by the end of the Grace Period, the Group Policy will be cancelled and coverage will terminate the first day following the end of the Grace Period.

The Company is not liable to pay any benefits for services, including those predetermined, which are performed after the Termination Date of a Member's coverage or of the Group Policy.

CONTINUATION COVERAGE

Federal law may require certain employers to offer continuation coverage to Members for a specified period of time upon termination of employment or reduction of work hours for any reason other than gross misconduct. You should contact Your employer to find out whether or not this requirement applies to You and Your employer. Your employer will advise You of Your rights to continuation coverage and the cost. If this requirement does apply, You must elect to continue coverage within 60 days from Your qualifying event or notification of rights by Your employer, whichever is later. You may elect to extend Dependent(s) coverage, or the Dependent(s) may elect to continue coverage under certain circumstances or qualifying events. Dependent(s) must elect to continue coverage within 60 days from the event or notification of rights by Your employer, whichever is later. You must pay the required premium for continuation coverage directly to your employer. The Company is not responsible for determining who is eligible for continuation coverage.

GENERAL PROVISIONS

This Certificate includes and incorporates any and all riders, endorsements, addenda, and schedules and together with the Group Policy represents the entire agreement between the parties with respect to the subject matter. The failure of any section or subsection of this Certificate shall not affect the validity, legality and enforceability of the remaining sections.

Except as otherwise herein provided, this Certificate may be amended, changed or modified only in writing and thereafter attached hereto as part of this Certificate.

The Company may assign this Certificate and its rights and obligations hereunder to any entity under common control with the Company.

This Certificate will be construed for all purposes as a legal document and will be interpreted and enforced in accordance with pertinent laws and regulations of the state indicated on the State Law Provisions Addendum.

ADDENDUM TO CERTIFICATE

APPEAL PROCEDURE

This Addendum is effective on the Effective Date stated in the Group Policy. It is attached to and made part of the Certificate.

If You are dissatisfied with Our benefit determination on a claim, You may appeal Our decision by following the steps outlined in this procedure. We will resolve Your appeal in a thorough, appropriate, and timely manner to ensure that You are afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the Plan documents and consistently among claimants. You or Your authorized representative may submit written comments, documents, records and other information relating to claims or appeals. We will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by Us required under these procedures will be supplied to You or Your authorized representative.

DEFINITIONS

The following terms when used in this document have the meanings shown below.

“Adverse benefit determination” is a denial, reduction, or termination of or failure to make payment (in whole or in part) based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is Experimental or Investigational or not Dentally Necessary or appropriate.

“Authorized representative” is a person granted authority by You and the Company to act on Your behalf regarding a claim for benefit or an appeal of an adverse benefit determination. An assignment of benefits is not a grant of authority to act on Your behalf in pursuing and appealing a benefit determination.

“Relevant” A document, record, or other information will be considered **“relevant”** to a given claim:

- a) if it was relied on in making the benefit determination;
- b) if it was submitted, considered, or generated in the course of making the benefit determination (even if the Plan did not rely on it);
- c) if it demonstrated that, in making the determination, the Plan followed its own administrative processes and safeguards for ensuring appropriate decision-making and consistency;
- d) or if it is a statement of the Plan’s policy or guidance concerning the denied benefit, without regard to whether it was relied upon in making the benefit determination.

PROCEDURE

You or Your authorized representative may file an appeal with Us within 180 days of receipt of an adverse benefit determination. To file an appeal, telephone the toll-free number listed in Your Certificate of Coverage or on Your ID card.

We will review the claim and notify You of Our decision within 60 days of the request for appeal. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination.

Notice of the appeal decision will include the following in written or electronic form:

- a) the specific reason for the appeal decision;
- b) reference to specific plan provisions on which the decision was based;
- c) a statement that You are entitled to receive upon request and free of charge, reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts;
- d) a statement of Your right to bring a civil action under ERISA; and
- e) the following statement: “You and your Plan may have other voluntary alternative 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 regulatory agency.”

ILLINOIS STATE LAW PROVISIONS ADDENDUM
TO
CERTIFICATE OF INSURANCE

This addendum is effective on the Effective Date as stated in the Certificate of Insurance "Certificate" and attached to and made part of the Certificate.

The following Definition of "Dependent" is deleted from the "DEFINITIONS" section of the Certificate and the following substituted only for Members of Policyholders headquartered in Illinois. The definition of Dependent in the Certificate remains the same for Members of Policyholders headquartered outside of Illinois:

Dependent(s) - Certificate Holder's enrolled spouse or domestic life partner and their dependents as defined by the Policyholder and/or state law and any enrolled child, adoptive child or stepchild of a Certificate Holder or an enrolled child subject to a court order or placed by an administrative agency with a Certificate Holder:

- (a) until the end of the month the child reaches the limiting age 26; or
- (b) until the end of the month which he/she reaches age 30, is an Illinois resident, served as a member of the active or reserve component of the Armed Forces and received a release or honorable discharge; or
- (c) to any age beyond the limiting age listed above if the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

For a child under the limiting age listed above, the following factors will not affect eligibility to enroll as a Dependent: financial dependency on or residency with the Certificate Holder; marital status; student status; employment; eligibility to enroll for coverage under another policy or contract; or any combination of these factors.

The following Definition of "Intoxication" is added to the "Definitions" section of the Certificate:

Intoxication – Intoxication means that which is defined by the laws of the jurisdiction where the loss or cause of the loss was incurred.

The Enrollment Changes subsection under "ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS" is deleted from the Certificate and the following substituted only for Members of Policyholders headquartered in Illinois. The subsection remains the same for Members of Policyholders headquartered outside of Illinois:

Enrollment Changes

After Your initial enrollment, there are certain life change events that permit You to add Dependents. These events are:

- birth
- adoption
- court order of placement or custody
- marriage.

To enroll a new Dependent as a result of one of these events, You must notify Your Group and supply the required enrollment change information within 31 days of the date You acquired the Dependent. The Dependent must meet the requirements detailed in the definition of Dependent in the Definitions section of this Certificate.

Except for newly born or adoptive children, coverage for the new Dependent will begin on the date specified in the enrollment information provided to Us as long as the Premium is paid.

Newly born children of a Member will be considered enrolled from the moment of birth. Adoptive children will be considered enrolled from the date of adoption or placement, except for those adopted or placed within 31 days of birth who will be considered enrolled Dependents from the moment of birth. In order for coverage of newly born or adoptive children to continue beyond the first 31 day period, the child's enrollment information must be provided to Us and the required Premium must be paid within the 31 day period.

For an enrolled Dependent child who is mentally or physically handicapped, evidence of his/her reliance on You for maintenance and support due to his/her condition must also be supplied to Us within 30 days after said Dependent attains the limiting age shown in the definition of Dependent. Such evidence will be requested based on information provided by the Member's physician but no more frequently than annually.

Dependent coverage may only be terminated when certain life change events occur. These events include:

- death of the Certificate Holder or a Dependent; or
- divorce or dissolution of domestic partnership of the Certificate Holder; or
- for a child, reaching the limiting age specified in the definition of Dependent.

The following provision is added to the "ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS" section of the Certificate.

Annual Open Enrollment

Prior to the annual anniversary of Your Group Policy You will be provided at least 30 days advance notification to elect changes to Your enrolled Dependent coverage. You must notify Your Group and supply the required enrollment change information to Your Group. The Dependent must meet the requirements detailed in the definition of Dependent in the Definitions section of this Certificate.

The following subsections "Disclosure of Limited Benefit", "Proof of Loss", "Time Payment of Claims", and "Unpaid Premium" are added to the "How the Dental Plan Works" section of the Certificate:

HOW THE DENTAL PLAN WORKS

Disclosure of Limited Benefit

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when You elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of Your benefit payment will be determined according to Your Policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-Participating Providers may bill Members for any amount up to the billed charge after the Plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

Proof of Loss

Written proof of loss must be furnished to Company at its said office in case of claim for loss for which this Certificate provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the Company is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claims

All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid no later than 30 days from receipt of due written proof of such loss. The Company may extend this 30-day period by no more than 15 days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Company. Failure to pay within such period shall entitle the insured to interest at the rate of nine percent (9%) per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar (\$1.00) need not be paid. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid quarterly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Unpaid Premium

Upon the payment of a claim under this Policy, any Premium then due and unpaid or covered by any note or written order may be deducted.

The following provisions are added to the "Termination-When Coverage Ends" section(s) of the Certificate:

TERMINATION-WHEN COVERAGE ENDS

Upon the death of the Certificate Holder, the Dependents' coverage, if any, continues for a period of at least 90 days subject to any other policy provisions relating to termination of Dependents' coverage.

The following subsections "Termination of Continuation/Right of Continuation", "Dependent Child Privilege" and "Termination of Continuation/Right to Continuation" are added to the "Continuation" section of the Certificate.

CONTINUATION

Spousal Continuation Privilege

A. Certificate Holder's spouse and dependent children are eligible for continuation if:

1. the marriage is dissolved by judgment
2. death of the Certificate Holder
3. retirement of the Certificate Holder

In the event of marriage dissolution by judgment or the death or retirement of the Certificate Holder, the spouse must provide Your Group or the Company a written notice dissolution of the marriage or the death or retirement within 30 days of the coverage termination date if continuation of benefits is desired.

If the written notification is sent to Your Group rather than the Company, within 15 days of receiving the notice, Your Group must notify the Company the marriage is dissolved by judgment, the Certificate Holder's Death, or retirement. Your Group must also immediately send a copy of the notice to the former spouse or the spouse of the retired employee.

Within 30 days after receiving the written notification from Your Group, retired Certificate Holder's spouse or former spouse, of the initiation of a new Group Policy, the Company must notify by certified mail with return receipt requested, that the Policy may be continued for the retired Certificate Holder's spouse or retired spouse and dependents. This notice must include:

1. An election form to continue the insurance coverage,
2. The amount of premiums and the method and place of payment, and
3. Instructions for returning the form within 30 days after it is received from the Company.

Failure of the former spouse to exercise election within 30 days of the date he/she received notice from the Company terminates continuation of benefits and the right to continuation.

If the Company fails to notify the retired Certificate Holder's spouse or former spouse as required, all Premiums must be waived and the benefits must continue under the terms and provisions of the Policy from the date the notice was required until it was actually sent, unless the benefits are terminated for all Certificate Holders in the Group at the time the notice was to be sent.

In the event that the Group Policy is cancelled and another insurance company is contracted to provide insurance to Your Group and You, or You would have been included under the new Group Policy and the continuation coverage is in effect for the former spouse at the time of cancellation, the former spouse must be offered continuation coverage under the new policy as prescribed by this law.

Premium Computation

With respect to a former spouse who has not attained the age of 55 at the time continuation coverage begins, the monthly Premium for continuation must be computed as follows:

1. An amount, if any, that would be charged to a Certificate Holder if the former spouse were a current Certificate Holder, plus;

2. An amount, if any, that the Policyholder would contribute toward the Premium if the former spouse were a current Certificate Holder.

Failure to pay the initial monthly Premium within 30 days of the date the former spouse received notice from the Company terminates the continuation benefits and the right to continuation benefits.

With respect to a retired Certificate Holder's spouse or former spouse who has attained the age of 55 at the time continuation coverage begins, the monthly Premium for continuation must be computed as follows:

1. An amount, if any, that would be charged to a Certificate Holder if the retired Certificate Holder's spouse or former spouse were a Certificate Holder, plus;
2. An amount, if any, that the Policyholder employer would contribute toward the Premium if the retired Certificate Holder's spouse or former spouse were a current Certificate Holder.

Beginning 2 years after coverage begins under this paragraph, the monthly Premium will be computed as follows:

1. An amount, if any that would be charged a Certificate Holder if the retired Certificate Holder's spouse or former spouse were a current Certificate Holder, plus;
2. An amount, if any, that the Policyholder would contribute toward the premium, if the retired Certificate Holder's spouse or former spouse were a current Certificate Holder.
3. An additional amount, not to exceed 20% of (1) and (2) above, for costs of administration.

Failure to pay the initial monthly Premium within 30 days of the date the former spouse received notice from the Company terminates the continuation benefits and the right to continuation benefits.

Termination of Continuation/Right to Continuation

Continuation coverage will be terminated for a former spouse (divorced or surviving the Certificate Holder's death) who has not reached the age of 55 for any of the following events, whichever occurs first:

1. Failure to pay Premiums when due including any Grace Period allowed,
2. The date coverage would terminate under the existing Policy terms even if the former spouse and the Certificate Holder were still married to each other. However, continuation coverage may not be modified or terminated during the first 120 consecutive days subsequent to the Certificate Holder's death or divorce unless the existing policy was modified or terminated for the Group,
3. The date on which the former spouse first becomes, after the date of election, an insured Certificate Holder under any other group health plan,
4. The date on which the former spouse remarries, or
5. The expiration of two (2) years from the date continuation coverage began.

Continuation coverage will be terminated for a former spouse (divorced or surviving the Certificate Holder's death) or a retiree's spouse who has reached the age of 55 for any of the following events, whichever occurs first.

1. Failure to pay Premiums when due including any Grace Period allowed,
2. The date coverage would terminate under the existing policy terms, except in the event of the Certificate Holder's retirement, even if the former spouse and the Certificate Holder were still married to each other. However, continuation coverage may not be modified or terminated during the first 120 consecutive days subsequent to the Certificate Holder's death or divorce unless the existing policy was modified or terminated for the Group,

3. The date on which the former spouse or the retiree's spouse first becomes, after the date of election, an insured Certificate Holder under any other group health plan,
4. The date on which the former spouse remarries, or
5. The date on which the former spouse or retiree's spouse is eligible for Medicare.

Conversion Option Former Spouse or Retiree Spouse

Upon termination of continuation coverage, the Company must offer the former spouse the option to convert coverage to an individual conversion policy without providing evidence of insurability. To convert coverage, the Certificate Holder must make written application for him/herself and pay the first three month's Premium to the Company within 31 days after termination of continuation coverage under this Certificate. Coverage under the conversion policy become effective on the date the coverage under this Certificate terminates.

Dependent Child Continuation Privilege

A Dependent child is eligible for continuation if:

1. In the event of the Certificate Holder's death, the child does not qualify for the extension of continuation rights under the spousal provisions discussed above, or
2. The child has attained the limiting age under the Certificate Holder's policy.

In the event of the Certificate Holder's death, the Dependent child or an adult acting on behalf of the child must provide Your Group or the Company a written notice of the death within 30 days of the coverage termination date if continuation of benefits is desired.

In the event that a Dependent child attained the limiting age under the Certificate, the Dependent child must provide Your Group or the Company a written notice of this fact within 30 days of the coverage termination date if continuation of benefits is desired.

If the written notification is sent to Your Group rather than the Company, within 15 days of receiving the notice, Your Group must notify the Company of the Certificate Holder's death or the attainment of age of the Dependent child and the residence of the Dependent child. In the event of the Certificate Holder's death, Your Group must also immediately send a copy of the notice to the Company, to the Dependent child, or to the adult acting on behalf of the dependent child at the child's residence.

Within 30 days after receiving the written notification from Your Group or from the Dependent child or the adult acting on behalf of the child, or within 30 days of the initiation of a new Group Policy, the Company must notify the Dependent child at his/her residence, by certified mail with return receipt requested, that the Policy may be continued for the Dependent child. This notice must include:

1. An election form to continue the insurance coverage,
2. The amount of premiums and the method and place of payment, and
3. Instructions for returning the form within 30 days after it is received from the Company.

If the Company fails to notify the child or the adult acting on behalf of the child as required, all Premiums must be waived and the benefits must continue for the Dependent child under the terms and provisions of the Policy from the date the notice was required until it was actually sent, unless the benefits are terminated for all Certificate Holders in the Group at the time the notice was to be sent.

The monthly Premium for continuation must be computed as follows:

1. An amount, if any, that would be charged to a Certificate Holder if the Dependent child were a current employee.
2. An amount, if any, that the Certificate Holder would contribute toward the premium if the Dependent child were a current employee.

In the event that the Group Policy is cancelled and another insurance company is contracted to provide insurance to Your Group and You, or You would have been included under the new Group Policy and the continuation coverage is in effect for the Dependent child at the time of cancellation, the Dependent child must be offered continuation coverage under the new policy as prescribed by this law.

Termination of Continuation/Right to Continuation

A Dependent child's continuation benefits (i.e., the actual benefits) and the right to continuation benefits (i.e., the right to elect continuation of benefits) will terminate if any of the following occurs:

1. Failure of the Dependent child or the adult acting on behalf of the Dependent child to exercise election within 30 days of the date he/she received notice from the Company terminates continuation of benefits and the right to continuation.
2. Failure to pay the initial monthly Premium within 30 days of the date the Dependent child received notice from the Company terminates the continuation benefits and the right to continuation benefits.
3. Whichever of the following happens first:
 - The failure to pay premiums when due, including any Grace Period allowed by the Policy,
 - The date coverage would terminate under the terms of the existing Policy if the Dependent child was still an eligible Dependent of the Certificate Holder,
 - The date on which the Dependent child first becomes, after the date of election, an insured Certificate Holder under any other group health plan, or
 - The expiration of 2 years from the date continuation coverage began.

Conversion Option of Dependent Child

Upon termination of continuation coverage, the Company must offer the Dependent child the option to convert coverage to an individual conversion policy without providing evidence of insurability. To convert coverage, the Certificate Holder must make written application for him/herself and pay the first three month's Premium to the Company within 31 days after termination of continuation coverage under this Certificate. Coverage under the conversion policy become effective on the date the coverage under this Certificate terminates.

The following provision and subsections "Time Limit On Certain Defenses" and "Legal Actions" are added to the "General Provisions" section(s) of the Certificate:

GENERAL PROVISIONS

The pertinent laws and regulations for interpretation and enforcement of the Certificate are the laws and regulations of Illinois.

Time Limit On Certain Defenses

After two (2) years from the date of issue of this Certificate, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of such two-year period. The foregoing Policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period.

Legal Actions

No civil action shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

United Concordia Life and Health Insurance Company
Summary of Coverage

You are encouraged to review and familiarize yourself with benefit information in the attached Summary of Coverage. SINCE THE DESCRIPTION OF COVERAGE IS NOT A LEGAL DOCUMENT, for full benefit information please refer to your contract or certificate, or contact your dental care plan at the toll-free number. In the event of any inconsistency between your Summary of Coverage and contract or certificate, the terms of the contract or certificate will control.

Plan: Concordia PPO

Name: United Concordia Life and Health Insurance Company

Address: 4401 Deer Path Road, Harrisburg, PA 17110

Toll Free Member Services Telephone Number: 1-888-638-3384

Web site: www.unitedconcordia.com

Summary of Coverage	
Basics	
Deductible	Your plan may have a deductible. Refer to the Schedule of Benefits to determine if your plan has a deductible.
Maximums	Your plan may have a maximum. Refer to the Schedule of Benefits to determine if your plan has a maximum.
You Pay	The amounts listed on the Schedule of Benefits for services rendered by your dentist. You will be responsible for payments for deductibles and payment for services that exceed the maximum.
Pre-existing Condition Limitations	There are no pre-existing condition limitations for this plan.
Maximum Allowable Charge	Maximum Allowable Charges are the maximum amount the Plan will allow for a Covered Service during a specified period. Maximum Allowable Charges may vary depending upon the Plan selected.
Description of Coverage	
Dental Care Plan Covers	All covered services are listed on the Schedule of Benefits.

	Dental Care Plan Coverage
Exclusions and Limitations	Plan exclusions include: cosmetic dentistry, hospitalization costs, general anesthesia, nitrous oxide or IV sedation, and services that are the responsibility of another insurer. Certain services are limited by age, such as fluoride treatments and sealants. Other services are limited by frequency, such as routine exams and cleanings, certain x-rays, and replacement of crowns. Please see the Schedule of Exclusions and Limitations for a detailed listing of all plan exclusions and limitations.
Emergency Care	A dental emergency is an acute condition which, in the opinion of the Company, occurs suddenly, is unexpected, usually includes pain, swelling or bleeding and demands immediate professional dental services. Refer to Schedule of Benefits for coverage of palliative treatment in accordance with the American Dental Association guidelines for emergency care.
Dental Necessity	A dental service or procedure is determined by a dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the dentist and the prevailing standards of care in the professional community. The determination will be made by the dentist in accordance with guidelines established by the Company. When there is a conflict of opinion between the dentist and the Company on whether or not a dental service or procedure is Dentally Necessary, the opinion of the Company will be final.
Renewability	An amendment to the Group Policy shall be proposed by the Company to the Policyholder in writing at least 31 days prior to the Renewal Date. Except as otherwise provided each amendment shall become effective on the date the Group Policy renews in accordance with general policy rules.
Right to Change Premium	A change in the Premium or Schedule of Benefits shall be proposed by the Company to the Policyholder in writing at least 31 days prior to the Renewal Date. An amendment to change the Premium or Schedule of Benefits shall become effective on the date the Group Policy renews in accordance with general policy rules.

IMPORTANT: In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.

UNITED CONCORDIA
ADDENDUM
TO
GROUP POLICY AND CERTIFICATE OF INSURANCE

This Addendum is effective on the Effective Date as stated in the Group Policy and attached to and made part of the Group Policy and Certificate of Insurance.

The following language is added to the Group Policy and Certificate of Insurance:

The Company uses Maximum Allowable Charge schedules to determine claim payments. Payment is the lesser of the dentist's submitted charge or the Maximum Allowable Charge.

Maximum Allowable Charges for Covered Services are determined by geographical area of the dental office. The Maximum Allowable Charges in the geographical area of the dental office are used to calculate the Company's payment on claims. Maximum Allowable Charges are reviewed periodically and adjusted as appropriate to reflect increased dentist fees within the geographical areas. Participating Dentists accept their contracted Maximum Allowable Charges as payment in full for Covered Services.

FEDERAL LAW SUPPLEMENT
TO
CERTIFICATE OF INSURANCE

This Supplement amends your Certificate by adding the following provisions regarding special enrollment periods and extended coverage requirements currently mandated or that may be mandated in the future under federal law.

You may enroll for dental coverage at any time for yourself and your dependents if:

- (1) You or your dependent either loses eligibility for coverage under Medicaid or the Children's Health Insurance Program ("CHIP"); or
- (2) You or your dependent becomes eligible for premium assistance from Medicaid or CHIP allowing enrollment in a benefit program.

In order to enroll, you must submit complete enrollment information to your group or its plan administrator within sixty (60) days from your or your dependent's loss of coverage or eligibility for premium assistance, as the case may be.

Other special enrollment periods and rights may apply to you or your dependents under new or existing federal laws. Consult your group, its plan administrator or your group's summary plan description for information about any new or additional special enrollment periods, enrollment rights or extended coverage periods for dependents mandated under federal law.

United Concordia Life and Health Insurance Company

a wholly owned subsidiary of United Concordia Companies, Inc.

4401 Deer Path Road, Harrisburg, PA 17110

Concordia PPOsm

Group Name: State of Maryland PPO

Group Number: 842843000, 842843001,

Effective Date: July 1, 2011

842843002, 842843004, 842843006,

842843007, 842843008, 842843009

	<u>Plan Pays</u>
Class I Services	
• Exams	100%
• All X-Rays	100%
• Cleanings & Fluoride Treatments	100%
• Sealants	100%
• Palliative Treatment (Emergency)	100%
Class II Services	
• Space Maintainers	70%
• Basic Restorative (Fillings, etc.)	70%
• Endodontics	70%
• Non-surgical Periodontics	70%
• Repairs of Crowns, Inlays, Onlays	70%
• Repairs of Bridges	70%
• Denture Repair	70%
• Simple Extractions	70%
• Surgical Periodontics	70%
• Complex Oral Surgery	70%
• General Anesthesia	70%
Class III Services	
• Inlays, Onlays, Crowns	50%
• Prosthetics (Bridges, Dentures)	50%
Orthodontics	
• Diagnostic, Active, Retention Treatment	50%
• Limited to Dependent children under the age of 26	

Deductibles & Maximums

- \$50 per Contract Year Deductible per Member (excluding Class I & Orthodontics) not to exceed \$150 per family
- \$1500 per Contract Year Maximum per Member
- \$2000 Lifetime Maximum per Member for Orthodontics

All services on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations. Consult Your Certificate for more details on the services listed.

Participating Dentists accept the Maximum Allowable Charge as payment in full.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – DPPO Plan

Except as specifically provided in the Certificate, Schedules of Benefits or Riders to the Certificate, no coverage will be provided for services, supplies or charges:

1. Not specifically listed as a Covered Service on the Schedule of Benefits and those listed as not covered on the Schedule of Benefits.
2. Which are necessary due to patient neglect, lack of cooperation with the treating dentist or failure to comply with a professionally prescribed Treatment Plan.
3. Started prior to the Member's Effective Date or after the Termination Date of coverage with the Company, including, but not limited to multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures.
4. Services or supplies that are not deemed generally accepted standards of dental treatment.
5. For hospitalization costs.
6. For prescription or non-prescription drugs, vitamins, or dietary supplements.
7. Administration of nitrous oxide, general anesthesia and i.v. sedation, unless specifically indicated on the Schedule of Benefits.
8. Which are Cosmetic in nature as determined by the Company, including, but not limited to bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures.
9. Elective procedures including but not limited to the prophylactic extraction of third molars.
10. For the following which are not included as orthodontic benefits - retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient neglect, or repair of an orthodontic appliance.
11. For congenital mouth malformations or skeletal imbalances, including, but not limited to treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment.
12. For dental implants including placement and restoration of implants unless specifically covered under a rider to the Certificate.
13. For oral or maxillofacial services including but not limited to associated hospital, facility, anesthesia, and radiographic imaging even if the condition requiring these services involves part of the body other than the mouth or teeth.
14. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under a Rider to the Certificate. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
15. For treatment of fractures and dislocations of the jaw.
16. For treatment of malignancies or neoplasms.
17. Services and/or appliances that alter the vertical dimension, including but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
18. Replacement of lost, stolen or damaged prosthetic or orthodontic appliances.
19. For broken appointments.
20. For house or hospital calls for dental services.
21. Replacement of existing crowns, onlays, bridges and dentures that are or can be made serviceable.
22. Preventive restorations in the absence of dental disease.
23. Periodontal splinting of teeth by any method.
24. For duplicate dentures, prosthetic devices or any other duplicative device.
25. For services determined to be furnished as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Health Occupations Article. Prohibited referrals are referrals of a patient to an entity in which the referring dentist, or the dentist's immediate family: (a) owns a beneficial interest; or (b) has a compensation arrangement. The dentist's immediate family includes the spouse, child, child's spouse, parent, spouse's parent, sibling, or sibling's spouse of the dentist, or that dentist in combination.
26. For which in the absence of insurance the Member would incur no charge.
27. For plaque control programs, oral hygiene, and dietary instructions.

28. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the national guard or in the armed forces of any country or international authority.
29. For training and/or appliance to correct or control harmful habits, including, but not limited to, muscle training therapy (myofunctional therapy).
30. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service. Failure to furnish the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the required time, if the claim is furnished as soon as reasonably possible and, except in the absence of legal capacity of the Member, not later than 1 year from the time claim is otherwise required.
31. Which are not Dentally Necessary as determined by the Company.
32. For prosthetic services including but not limited to full or partial dentures or fixed bridges, if such services replace one or more teeth missing prior to the Member's eligibility under the Company.

For Group Policies issued and delivered in Maryland, this exclusion does not apply to prosthetic services placed five years after the Member's Effective Date for services.

LIMITATIONS - DPPO

The following services will be subject to limitations as set forth below:

1. Full mouth x-rays – one every five years.
2. One set(s) of bitewing x-rays per six months through age thirteen, and one set(s) of bitewing x-rays per twelve months for age fourteen and older.
3. Periodic oral evaluation – two per consecutive twelve month period.
4. Limited oral evaluation (problem focused) – limited to one per dentist per twelve months.
5. Prophylaxis – two per twelve consecutive month period. One (1) additional for Members under the care of a medical professional during pregnancy.
6. Fluoride treatment – two per consecutive twelve month period.
7. Space maintainers - only eligible for Members through age eighteen when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not develop.
8. Prefabricated stainless steel crowns - one per tooth per lifetime for age fourteen years and younger.
9. Crown lengthening - one per tooth per lifetime.
10. Periodontal maintenance following active periodontal therapy – two per twelve months in addition to routine prophylaxis.
11. Periodontal scaling and root planing - one per two year period per area of the mouth.
12. Placement or replacement of single crowns, inlays, onlays, single and abutment buildups and post and cores, bridges, full and partial dentures – one within five years of their placement.
13. Denture relining, rebasing or adjustments - are included in the denture charges if provided within six months of insertion by the same dentist.
14. Subsequent denture relining or rebasing – limited to one every three year(s) thereafter.
15. Surgical periodontal procedures - one per two year period per area of the mouth.
16. Sealants - one per tooth per three year(s) through age fifteen on permanent first and second molars.
17. Pulpal therapy - through age five on primary anterior teeth and through age eleven on primary posterior molars.
18. Root canal treatment and retreatment – one per tooth per lifetime.
19. Recementations by the same dentist who initially inserted the crown or bridge during the first twelve months are included in the crown or bridge benefit, then one per twelve months thereafter; one per twelve months for other than the dentist who initially inserted the crown or bridge.
20. Replacement restorations – limited to one per twelve months.
21. Contiguous surface posterior restorations not involving the occlusal surface will be payable as one surface restoration.
22. Posts are only covered as part of a post buildup.
23. An Alternate Benefit Provision (ABP) will be applied if a dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed for the ABP.

United Concordia

Rider to Schedule of Benefits

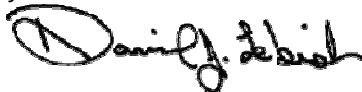
Preventive Incentive®

This Rider is effective on July 1, 2011 and is attached to and made a part of the Schedule of Benefits.

Benefits for the following services shown as covered on the Schedule of Benefits will not be counted toward accumulation of the program Maximum indicated on the Schedule of Benefits:

- Exams
- Cleanings (routine prophylaxis)
- All X-Rays
- Fluoride Treatments
- Sealants
- Palliative Treatment (Emergency)

United Concordia Life and Health Insurance
Company



Authorized Officer

United Concordia

Rider to Schedule of Benefits and Schedule of Exclusions and Limitations

Implantology

This Rider is effective on July 1, 2011 and is attached to and made a part of the Schedule of Benefits and Schedule of Exclusions and Limitations.

SCHEDULE OF BENEFITS

The Company will pay implantology benefits for eligible Members for the following Covered Services equal to 50% of the Maximum Allowable Charge.

Implantology Services

Surgical Services

- D6010 surgical placement of implant body: endosteal implant
- D6040 surgical placement: eposteal implant
- D6050 surgical placement: transosteal implant
- D6100 implant removal, by report

Supporting Structures

- D6055 dental implant supported connecting bar
- D6056 prefabricated abutment – includes placement
- D6057 custom abutment – includes placement

Implant/Abutment Supported Removable Dentures

- D6053 implant/abutment supported removable denture for completely edentulous arch
- D6054 implant/abutment supported removable denture for partially edentulous arch

Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)

- D6078 implant/abutment supported fixed denture for completely edentulous arch
- D6079 implant/abutment supported fixed denture for partially edentulous arch

Single Crowns, Abutment Supported

- D6058 abutment supported porcelain/ceramic crown
- D6059 abutment supported porcelain fused to metal crown (high noble metal)
- D6060 abutment supported porcelain fused to metal crown (predominantly base metal)
- D6061 abutment supported porcelain fused to metal crown (noble metal)
- D6062 abutment supported cast metal crown (high noble metal)
- D6063 abutment supported cast metal crown (predominantly base metal)
- D6064 abutment supported cast metal crown (noble metal)
- D6094 abutment supported crown – (titanium)

Single Crowns, Implant Supported

- D6065 implant supported porcelain/ceramic crown
- D6066 implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
- D6067 implant supported metal crown (titanium, titanium alloy, high noble metal)

Fixed Partial Denture, Abutment Supported

- D6068 abutment supported retainer for porcelain/ceramic FPD
- D6069 abutment supported retainer for porcelain fused to metal FPD (high noble metal)
- D6070 abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
- D6071 abutment supported retainer for porcelain fused to metal FPD (noble metal)
- D6072 abutment supported retainer for cast metal FPD (high noble metal)
- D6073 abutment supported retainer for cast metal FPD (predominantly base metal)
- D6074 abutment supported retainer for cast metal FPD (noble metal)
- D6194 abutment supported retainer crown for FPD – (titanium)

MDR-Implant (03/07)

Fixed Partial Denture, Implant Supported

- D6075 implant supported retainer for ceramic FPD
- D6076 implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
- D6077 implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)

Other Repair Procedures

- D7950 osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report
- D7951 sinus augmentation with bone or bone substitutes
- D7953 bone replacement graft for ridge preservation – per site

Deductible(s)

The annual Deductibles indicated on the Schedule of Benefits will be applied to implantology services.

Maximum(s)

The annual Maximum indicated on the Schedule of Benefits will be applied to implantology services.

Waiting Period(s)

No Waiting Period will be applied to implantology services.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

The Schedule of Exclusions and Limitations is amended as follows:

Exclusions

Any exclusions relating to implantology services are deleted.

Limitations

The following limitation does not apply to the above listed implantology procedures:

An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist.

The following limitations are added to the Schedule of Exclusions and Limitations:

Implantology services are limited to one (1) per tooth per lifetime.

Implantology services are limited to Member's age eighteen (18) and older.

UNITED CONCORDIA LIFE AND HEALTH
INSURANCE COMPANY



MDR-Implant (03/07)

Authorized Officer