United Concordia Dental Plans, Inc.

4401 Deer Path Road
Harrisburg, PA 17110

Dental Plan
Certificate of Coverage
State of Maryland

CERTIFICATE OF COVERAGE

INTRODUCTION

This Certificate of Coverage 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 Contract with United Concordia. The benefits are available to You as long as the Premium is paid and obligations under the Group Contract are satisfied. In the event of conflict between this Certificate and the Group Contract, the Group Contract 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, In-Network 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 69422
Harrisburg, PA 17106-9422

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ATTACHED:

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 apply to Your benefits and the way the dental Plan works.

Certificate Holder(s) - An individual who, because of his/her status with the Contractholder, has enrolled him/herself and/or his/her eligible Dependents for dental coverage and for whom Premiums are paid. In the case of a Group Contract that covers only dependent children, the Certificate Holder must be the child's or children's parent, stepparent, grandparent, legal guardian, or legal custodian, Also referred to as "You" or "Your" or "Yourself".

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

Company –United Concordia Dental Plans, Inc.

Contractholder - Organization that executes the Group Contract. Also referred to as "Your Group".

Contract Year - The period of twelve (12) months beginning on the Group Contract's Effective Date or the anniversary of the Group Contract's Effective Date and ending on the day before the Renewal Date.

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

Copayments - Those amounts set forth in the Schedule of Benefits that the Member is responsible to pay the treating Dentist.

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

Covered Service(s) - Services or procedures shown on the Schedule of Benefits for which benefits will be covered subject to the Schedule of Exclusions and Limitations, when rendered by In-Network Dentists in accordance with the terms of this Certificate.

Dental Emergency - An acute condition occurring suddenly and unexpectedly, which usually includes pain, swelling or bleeding, and demands immediate professional dental services.

Dentist(s) - A person licensed to practice dentistry in the state in which dental services are provided. Dentist will include any other duly licensed dental professional practicing under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

Dependent(s*)* - Those individuals eligible to enroll for coverage under the Group Contract because of their relationship to the Certificate Holder.

This Group Contract is a Family Contract. Dependents eligible for coverage in this Family Contract include:

1. The Certificate Holder's Spouse and
2. Any unmarried natural child, stepchild, grandchild, adopted child or child placed with the Certificate Holder or the Certificate Holder's Spouse or domestic partner:

   (a) until the end of the month; that the child reaches age twenty six (26); or
   (b) to any age if the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical incapacity and chiefly dependent upon the Certificate Holder for support

3. Any unmarried natural child, stepchild, grandchild, adopted child or child placed for adoption with the Certificate Holder or the Certificate Holder's Spouse or domestic partner by order of a court or administrative agency, subject to 3 a-c above. In this case:
a. the insuring parent shall be allowed to enroll in a family members' coverage and include the child in that coverage regardless of enrollment period restrictions;
b. if the insuring parent is enrolled in health insurance coverage but does not include the child in the enrollment, then:
(i)The non-insuring parent, child support enforcement agency, or Department of Health and Mental Hygiene may apply for enrollment on behalf of the child; and
(ii) include the child in the coverage regardless of enrollment period restrictions; and
c. We will not terminate health insurance coverage for the child unless written evidence is provided to the entity that:
(i) the order is no longer in effect;
(ii) the child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;
(iii) the employer has eliminated family members' coverage for all of its employees; or
(iv) the employer no longer employs the insuring parent, except that if the parent elects to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage shall be provided for the child consistent with the employer's plan for postemployment health insurance coverage for dependents.
4. Any unmarried natural child, stepchild, grandchild, by order of a court or administrative agency subject to 3 a-c above, who is under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration, of the insured, subscriber, employee, or member.

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

Exclusion(s) – Services, supplies or charges that are not covered under the Group Contract 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.

Family Contract - A Group Contract that covers the Contractholder's Certificate Holders and may also cover eligible Dependents, as defined in this Evidence of Coverage. A Group Contract that covers only Subscribers' children is not a Family Contract.

Grace Period - A period of thirty (30) days granted for payment of each premium due after the first premium, unless the dental plan organization does not intend to renew the contract beyond the period for which premium has been accepted and notice of the intention not to renew is delivered to the contract holder at least forty-five (45) days before the premium is due. During the grace period the contract shall continue in force.

Group Contract - The agreement between the Company and the Contractholder, under which the Certificate Holder is eligible to enroll him/herself and/or his/her Dependents.

In-Network Dentist – A Primary Dental Office or a Specialty Care Dentist.

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.

Maryland Health Connection – The Health Insurance Marketplace authorized by law or regulation in the state of Maryland through which individuals and groups can purchase insurance to meet the requirements of the federal Affordable Care Act. Maryland Health Connection also refers to any successor Maryland Health Insurance Marketplace established under the federal Affordable Care Act**.**

Member(s) – Enrolled Certificate Holder(s) and their enrolled Dependent(s). Also referred to as "You" or "Your" or "Yourself".

Out-of-Network Dentist - A general or specialty care Dentist who has not signed a contract Us. Also referred to as "Non-Participating Provider."

Out-of-Pocket Expense(s) - Cost not paid by Us, including but not limited to Copayments, amounts billed by Out-of-Network Dentists except as specified in the Dental Emergencies and Out-of-Network Care provision of this Certificate, costs of services that exceed the Group Contract's Limitations, Annual Maximum or Lifetime Maximums, or for services that are Exclusions. The Certificate Holder is responsible for Out-of-Pocket Expenses.

Out-of-Pocket Maximum - The limit on Copayments and Deductibles from Primary Dentists and Specialty Care Dentists that the Certificate Holder is required to pay in a Contract Year, as shown on the Schedule of Benefits. After this limit is reached, Covered Services from Primary Dental Providers and Specialty Care Dentists is paid 100% by the Plan for the remainder of the Contract Year, subject to the Schedule of Exclusions and Limitations.

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

Premium - Payment made by the Contractholder in exchange for coverage of the Contractholder's Members under this Group Contract.

Primary Dental Office/Provider - Approved office of a Primary Dentist who has executed a contract with Us to offer Covered Services to Members.

Primary Dentist - A general Dentist whose office has executed a contract with Us, under which he/she agrees to provide Covered Services to Members for a monthly fee plus any applicable supplements and Copayments, as payment in full for services rendered.

Renewal Date - The date on which the Group Contract renews. Also known as "Anniversary Date".

Schedule of Benefits - Attached summary of Covered Services and Copayments, Waiting Periods and maximums applicable to benefits, services, supplies or charges 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.

Service Area – The state of Maryland.

Special Enrollment Period - The period of time outside Your Group's open enrollment period during which individuals eligible as Certificate Holders or Dependents who experience certain qualifying events may enroll in this Group Contract.

Specialty Care Dentist - A specialized Dentist who is board eligible, board qualified, or board certified in one of the specialty areas of periodontics, oral surgery, orthodontics, endodontics and pediatrics and who has executed a contract with Us to accept negotiated fees plus any applicable Copayments, as payment in full for Covered Services provided to Members.

Spouse – The Certificate Holder's partner by marriage or by any union between two adults that is recognized by law in Maryland.

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

We, Our or Us - The Company, its affiliate or an organization with which it contracts for a provider network and/or to perform certain functions to administer this Group Contract.

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

In order to be a Member, You must meet the eligibility requirements of Your Group and this Group Contract. If You are enrolling through Maryland Health Connection, You must meet any additional eligibility requirements of Maryland Health Connection and provide enrollment information to it. We must receive enrollment information for the Certificate Holder, enrolled Dependents, and Contractholder. Provided that We receive applicable Premium, coverage will begin on the date specified in the enrollment information We receive. Your Group will inform Certificate Holders of its eligibility requirements.

If You have already satisfied all eligibility requirements on the Group Contract Effective Date and Your enrollment information and applicable Premium is supplied to Us, Your coverage will begin on the Group Contract Effective Date.

If You are not eligible to be a Member on the Group Contract Effective Date, You must supply the required enrollment information on Yourself and any eligible Dependents, as specified in the Definitions section, within thirty-one (31) days of the date You meet the applicable eligibility requirements.

Coverage for Members enrolling after the Group Contract Effective Date 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.

Special Enrollment Periods - Enrollment Changes

After Your Effective Date, You can change Your enrollment during Your Group's open enrollment period. There are also Special Enrollment Periods when an employee under a group contract may add or remove Dependents or himself. These life change events include:

- birth of a child or grandchild;
- adoption of a child;
- court order of placement or custody of a child;
- change in student status for a child or grandchild;
- loss of other coverage;
- marriage or other lawful union between two adults.

If You enrolled, or are eligible through Your Group, to enroll a new Dependent or Yourself as a result of one of these events, You must supply the required enrollment change information within thirty-one (31) days of the date of the life change event. The Dependent must meet the definition of Dependent applicable to this Group Contract.

The Certificate Holder may also add or remove Dependents or change Plans for the reasons defined by and during the timeframes specified by applicable law or regulation.

If You enrolled through Maryland Health Connection, or need to enroll due to a permitted life change event, there are additional life change events that may permit You to add or remove Dependents or Yourself, or change Plans. In addition to the life change events noted above, the additional Special Enrollment Period events that apply to participation through Maryland Health Connection include changes in:

- state of residence or access to a new QHP because of a permanent move;
- incarceration status;
- Enrollment or non-enrollment was unintentional, inadvertent or erroneous and the result of an error by the Exchange or HHS;
- A qualified plan substantially violated a material provision of its contract with the individual;
- Individuals who are Indians may change dental plans on the Exchange once per month;
- Individual or dependent demonstrates to the Exchange in accordance with HHS guidelines, that the individual meets other exceptional circumstances;
- Loss of eligibility for coverage under a Medicaid plan or CHIP plan, or an individual becomes eligible for assistance, with respect to coverage under the Maryland Health Connection, under such Medicaid or CHIP plan.

The Special Enrollment Period during which You must supply the required enrollment change information to Maryland Health Connection is thirty (30) days from the date of the life change event. You must supply the required enrollment change information to the Authorized Entity within sixty (60) days from the date of a loss of eligibility for coverage under a Medicaid or CHIP plan. The Dependent must meet the definition of Dependent applicable to this Group Contract.

Except for newly born or adoptive children, coverage for the new Dependent will begin on the the date specified in the enrollment information provided to Us or on the date dictated by Maryland Health Connection, in accordance with Federal Guidelines as long as the Premium is paid.

Newly born children and grandchildren 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 thirty-one (31) days of birth who will be considered enrolled Dependents from the moment of birth. A minor for whom guardianship is granted by court or testamentary appointment shall be considered enrolled from the date of appointment. In order for coverage of newly born or adoptive children to continue beyond the first thirty-one (31) day period, if additional premium is required to cover a newly enrolled dependent child, the child's enrollment information must be provided to Us and the required Premium must be paid within the thirty-one (31) day period. If you enrolled for pediatric coverage certified by the Maryland Health Connection, once three children are covered under the plan, no additional premiums are required for subsequent children, and We will not terminate coverage after thirty-one (31) days at this point, even if the enrollment information is not provided within the thirty-one (31) day time period.

A child or grandchild of a Certificate Holder will not be denied the status of Dependent on the grounds that the child or grandchild: (a) was born out of wedlock; (b) is not claimed as a dependent on the Certificate Holder's federal income tax return; (c) does not reside with the Certificate Holder or in the Company's Service Area.

For an enrolled Dependent child who is a full-time student, proof of his/her student status and reliance on You for support must be furnished to Us within thirty (30) days after he/she reaches the limiting age shown in the definition of Dependent. The Company will send notification to the Member at least ninety (90) days prior to the date the dependent child attains the limiting age. Such evidence will be requested annually thereafter until the Dependent reaches the limiting age for students and his/her coverage ends.

For an enrolled Dependent child who is mentally or physically incapacitated, proof of his/her reliance on You for support due to his/her condition must be supplied to Us within thirty (30) days after said Dependent attains the limiting age shown in the definition of Dependent. The Company will send notification to the Member at least ninety (90) days prior to the date the dependent child attains the limiting age. 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 dissolution of the union or domestic partnership, reaching the limiting age or during open enrollment periods or when otherwise permitted by applicable law or regulation intended to implement the Federal Affordable Care Act or specified in any applicable Late Entrant Rider to the Certificate of Coverage.

Late Enrollment

If You or Your Dependents are not enrolled within thirty-one (31) days of initial eligibility or during the Special Enrollment Period specified for a life change event, You or Your Dependents cannot enroll until the next Special Enrollment Period or open enrollment period conducted for Your Group unless otherwise permitted by applicable law or regulation intended to implement the federal Affordable Care Act. If You are required by court order to provide coverage for a Dependent child, You will be permitted to enroll the Dependent child without regard to enrollment season restrictions.

Voluntary Disenrollment

If You chose to drop Your coverage or Your Dependents' coverage under the Plan at any time during the contract year other than at open enrollment or during open enrollment, you will not be permitted to enroll Yourself or Your dependents at a later time unless You supply proof of loss of coverage under another dental plan. The loss of coverage must be due to a valid life change event. If you supply such proof, you will be permitted to re-enroll**.**

HOW THE DENTAL PLAN WORKS

Choice of Provider at Enrollment

You must select a Primary Dental Office for Yourself and Your Dependents. Each Member may select a different Primary Dental Office. If You or Your Dependents do not select a Primary Dental Office, You will be assigned to one in a location convenient to Your home zip code. The Primary Dental Office(s) will be notified of Your selection or assignment.

To find a Primary Dental Office, visit Our website or call Us at the toll-free number in the Introduction section of this Certificate or on Your ID card.

Once enrolled, You will receive an ID Card or other notification indicating Your contract ID number, plan number, Group number and the names of the Primary Dental Offices You and Your Dependents selected or that were assigned by Us. Present Your ID card to Your dental office or give the office Your ID number, Plan number and Group number. If Your Dentist has questions about Your eligibility or benefits, instruct the office to call Us or visit Our website*.*

Changing Primary Dental Offices

You or Your Dependents may request to change Primary Dental Offices at any time. Simply call our Customer Service center toll-free at the number in the Introduction section of this Certificate or visit Our website*.* You will be informed of the effective date of the transfer, and the newly selected office will also be notified. You must request the transfer prior to seeking services from the new Primary Dental Office. Any dental procedures in progress must be completed before the transfer.

If You or Your Dependents are enrolled in a Primary Dental Office that stops participating in the Plan, We will notify You and assist You or Your Dependents with selecting another Primary Dental Office.

Continuity of Care

If Your Primary Care Dentist or Specialty Care Dentist no longer participates with the Plan, coverage for completion of a dental procedure will be extended for a period of at least ninety (90) days from the date of the notice of a Primary Dental Office's or Specialty Care Dentist's termination from the Plan for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status. The Primary Dental Office or Specialty Care Dentist shall render dental services to any of the Plan's Members who:

- were receiving dental services from the In-Network Dentist prior to the notice of termination; and
- after receiving notice of the In-Network Dentist's termination, request to continue receiving dental services from that Dentist.

Coordination of Care and Referrals

The Primary Dental Office assigned to You or Your Dependents must provide or coordinate all Covered Services. When specialty care such as surgical treatment of the gums or a root canal is needed, the Primary Dentist may perform the procedure or give You a written referral to a Specialty Care Dentist. All benefits must be provided by In-Network Dentists, with the exception of Dental Emergencies or if a Primary Dentist or Specialty Care Dentist is not available in Your area, Standing Referrals, or Out-of-Network referrals as described in this section. See the next sections for details on these situations.

When specialty care such as surgical treatment of the gums or a root canal is needed, the Primary Dentist may perform the procedure or refer You to a specialist. All referrals must be made to a participating Specialty Care Dentist. Your Primary Dentist will give You a written referral to take to the Specialty Care Dentist. The Specialty Care Dentist will perform the treatment and submit a claim and the referral to Us for processing. The claim will be denied if the written referral is not submitted. Referral is limited to endodontic, orthodontic, periodontic, oral surgery, and pedodontic Specialty Care Dentists.

Standing Referral Guidelines

For standing referrals, You are not required to see Your Primary Dental Office prior to appointments with the Specialty Care Dentist. A standing referral for Your Covered Services is made under a written treatment plan by the Specialty Care Dentist and the Primary Dental Office.

The Company will allow a standing referral to a Specialty Care Dentist when all of the following conditions are met:

- Your Primary Dental Office (PDO) of the Member determines, in consultation with the Specialty Care Dentist, that the Member needs continuing care from the Specialty Care Dentist;
- You have a condition or disease that is life threatening, degenerative, chronic, or disabling that requires specialized care;
- the Specialty Care Dentist has expertise in treating such condition and is part of the Company's provider network.

The Primary Dental Office must complete the *Specialty Referral/Claim Form* specifying the services referred to the Specialty Care Dentist. The referral should explain why the standing referral is necessary.

You should take the *Specialty Referral/Claim Form* to the Specialty Care Dentist at Your first appointment. The Specialty Care Dentist provides treatment at each appointment and submits a copy of the *Specialty Referral/Claim Form* to Us.

Out-of-Network Referral Guidelines

The Company will allow You a referral to an Out-of-Network specialist if all of the following conditions are met:

- You are diagnosed with a condition or disease that requires specialized care;

- The Company does not have a Specialty Care Dentist in its panel with the training and expertise to treat the condition or disease;
- The Company cannot provide reasonable access to a Specialty Care Dentist with the professional training and expertise to treat or provide dental services for the condition or disease without unreasonable delay or travel.
- You are responsible only for the applicable copayment, as indicated on the Schedule of Benefits.

The Primary Dental Office (PDO) must complete the *Specialty Referral/Claim Form* specifying the services referred to the Out-of-Network specialist. The referral will explain the need for specialized care and why an Out-of-Network specialist is needed. The Primary Dental Office should contact Customer Service to notify the Company of the Out-of-Network referral and to receive the authorization number.

You should take the *Specialty Referral/Claim Form* to the Out-of-Network specialist. The Out-of-Network specialist provides treatment and submits the *Specialty Referral/Claim Form* to the Company.

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 Our website.

If a plan dentist refers You to a specialist who is not a plan dentist for covered dental services under the dental benefit contract, We shall be responsible for payment of the specialist's charges to the extent the charges exceed the copayment specified in the dental benefit contract.

Dental Emergencies

When immediate dental treatment is required as a result of a Dental Emergency and You are more than fifty (50) miles from Your home when the Dental Emergency occurs, contact Your Primary Dental Office or go to a conveniently located general Dentist. Ask the dental office to call Our Customer Service unit to verify coverage. Be sure to get an itemized bill from the dental office to submit to Us. The Plan will cover certain diagnostic and therapeutic procedures in accordance with the Schedule of Exclusions and Limitations. Your out-of-pocket cost will be limited to any applicable Copayment on the Schedule of Benefits.

Out-of-Network Care

When a Specialty Care Dentist is not available within a thirty (30) mile radius of Your home, We may authorize treatment by an Out-of-Network Dentist. Call Our Customer Service unit at the telephone number listed in the Introduction section of this Certificate. The unit will assist You by arranging a visit to an Out-of-Network Dentist. You are liable for only the applicable Copayment, as indicated in Your Schedule of Benefits, as long as the procedure is a Covered Service.

In addition, a Standing Referral and Out-of-Network referral, as described in the Coordination of Care and Referrals section, will provide You with a benefit for Out-of-Network care.

BENEFITS

Covered Services

Benefits and any applicable Copayments, Deductibles, Annual Maximums, Lifetime Maximums, Out-of-Pocket Maximums and Waiting Periods are shown on the attached Schedule of Benefits. Certain Limitations may also be shown on the Schedule of Benefits. Services shown on the Schedule of Benefits as covered are subject to frequency or age Limitations detailed on the attached Schedule of Exclusions and Limitations.

Only services, supplies and procedures listed on the Schedule of Benefits are Covered Services. For items not listed (not covered), You are responsible for the full fee charged by the Dentist. No benefits will be paid for services, supplies or procedures detailed under the Exclusions on the Schedule of Exclusions and Limitations.

Exclusions

No benefits will be provided for services, supplies or charges detailed as Exclusions on the Schedule of Exclusions and Limitations. Services shown on the Schedule of Benefits as covered may also be subject to frequency or age Limitations as detailed on the attached Schedule of Exclusions and Limitations.

Copayments and Other Charges

In order to keep the Plan affordable for You and Your Group, the Plan includes certain cost-sharing features. First, not all dental procedures are covered. If the procedure is not listed on the Schedule of Benefits, it is not covered. You will be responsible to pay Your Dentist the full charge for uncovered services.

Certain procedures listed on the Schedule of Benefits require You to pay a Copayment. Copayments are listed in the right-hand column on the Schedule. You are responsible to pay the Copayments at the time of service unless You have made other arrangements with the Primary Dental Office or Specialty Care Dentist. Copayments are the same whether the service is provided by Your Primary Dentist or by a Specialty Care Dentist through referral. Services listed on the Schedule of Benefits with a “0” or “N/C” in the column require no Copayment from You.

Services listed on the Schedule of Benefits are also subject to Exclusions and Limitations. Be sure to review both the Schedule of Benefits and the Schedule of Exclusions and Limitations attached to this Certificate. Services not listed on the Schedule of Benefits, Exclusions, or those beyond stated Limitations are not covered and are Your responsibility.

Other Charges for Alternate Treatment

Frequently, several alternate methods exist to treat a dental condition. For example, a tooth can be restored with a crown or a filling, and missing teeth can be replaced either with a fixed bridge or a partial denture. We will make payment based upon the allowance for the less expensive procedure, provided that the less expensive procedure meets accepted standards of dental treatment. Our decision does not commit You to the less expensive procedure. However, if You and the Dentist choose the more expensive procedure, You are responsible for the additional charges beyond those paid or allowed by the Company.

Payment of Benefits

We will pay covered benefits directly to Your assigned Primary Dental Office or the Specialty Care Dentist. Payment is based on rates contracted with In-Network Dentists. All contracts between Us and the In-Network Dentists state that under no circumstances will the Member be liable to any Dentists for any sum owed by Us to the Dentists. In any instance We fail or refuse to pay the Dentist, such dispute is solely between the Dentist and Us, and, other than Copayments, You are not liable for any monies We fail or refuse to pay.

The Company’s compensation to Dentists who offer dental health care services to You may be based on a variety of payment mechanisms such as fee-for-service payments, salary, or capitation. Bonuses may be used with these various types of payment methods. For additional information about Our methods of paying Dentists, or the method(s) that apply to your Dentist, please call Us at the toll-free number in the introduction section of this Certificate.

If, during the term of this Contract, none of the In-Network Dentists can render necessary care and treatment to You due to circumstances not reasonably within Our control, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, or the disability of a significant number of the In-Network Dentists, then You may seek treatment from a licensed Out-of-Network Dentist of You choice. We will pay

You for the expenses incurred for the dental services with the following limitations: We will pay You for the services which are listed in the Copayment schedule as No Charge, to the extent that such fees are reasonable and customary for Dentists in the same geographic area; We will also pay You for those services listed in the Contract for which there is a Copayment, to the extent that the reasonable and customary fees for such services exceed the Copayment for such services as set forth in the Contract. You may be required to give written proof of loss (file a claim). The Company agrees to be subject to the jurisdiction of the Maryland Insurance Commissioner in any dispute about the possibility of providing services by In-Network Dentists.

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 necessary, reasonable and customary 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; however if the Covered Person is a Medicare Beneficiary, then Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent.
    C) Dependent Child/Parents Who are Married or are Living Together -- The rules for the order of benefits for a Dependent child when the parents are married or are living together 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 or Parents Who Are no Longer Living Together -- If two or more plans cover a person as Dependent child of divorced or separated parents, or parents who are no longer living together, benefits for the child are determined in this order:
1) First, the plan of the parent with custody of the child.
2) Second, the plan of the spouse of the parent with the custody of the child; and
3) Third, the plan of the parent not having custody of the child.
4) Finally the plan of the spouse of the parent not having custody of the child.
5) 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.
6) 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) The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
2) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
3) This rule does not apply if the rule in Paragraph (3.B) can determine the order of benefits.

F) The plan covering an individual as a COBRA or state continuee will be secondary to a plan covering that individual as a Member or a Dependent.

G) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary and the plan that covered the person for the shorter period of time is secondary. In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

H) 1. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

2. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.

3. The start of a new plan does not include: A change in the amount or scope of a plan's benefits; A change in the entity that pays, provides or administers the plan's benefits; or A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

4. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

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 state and 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 Contract, 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 or on Your ID card. 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

Member's coverage will end at 12:00 AM EST notice from:

- On the date You lose no longer meet Your Group's eligibility requirements; or
- On the date Premium payment ceases for You; or
- On the date You no longer meet the eligibility requirements for a Dependent, as defined in the Definitions section of this Certificate.

On the date the Certificate Holder's coverage ends or the Certificate Holder is no longer eligible to enroll his/her Dependents, Dependent coverage will end. If the Group Contract is cancelled, Certificate Holder and Dependent coverage will end on the Group Contract Termination Date. The Primary Dental Office or Specialty Care Dentist will notify You of Your Group Contract's termination if the In-Network Dentist is aware that the Group Contract has terminated. The In-Network Dentist will inform You of the charge for any scheduled dental services before performing the dental services.

If the Contractholder fails to pay Premium, Coverage will remain in effect during the Grace Period. If the Premium is not received within the Grace Period, coverage will be immediately cancelled on the first day following the expiration of the Grace Period. The Contractholder is liable for Premium accrued during the Grace Period.

We are not liable to pay any benefits for services that are started after Your Termination Date or after the Group Contract Termination Date. However, coverage for completion of a dental procedure requiring two (2) or more visits on separate days will be extended for a period of ninety (90) days after the Termination Date in order for the procedure to be finished. The procedure must be started prior to the 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. This extension does not apply if the Group Contract terminates for failure to pay Premium.

Services for orthodontic treatment will continue for sixty (60) days after the Termination Date if the orthodontist has agreed to or is receiving monthly payments; or until the later of sixty (60) days after the Termination Date or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving quarterly payments. This extension of orthodontic payment does not apply if coverage was terminated due to the individual's failure to pay Premium, the individual's fraud, or if coverage without interruption of benefits is provided by another health plan and the cost is less than or equal to the cost of coverage for the individual during the extension.

CONTINUATION COVERAGE

Federal or state law may require certain employers that meet certain criteria 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. Certain employers including churches and small businesses are not required to offer this coverage. Contact Your Group to find out if this applies to You. Your Group will advise You of Your rights to continuation coverage and the cost. If this requirement does apply, You must elect to continue coverage within sixty (60) days from Your qualifying event or notification of rights by Your Group, whichever is later. Dependents may have separate election rights, or You may elect to continue coverage for them. You must pay the required premium for continuation coverage directly to Your Group. The Company is not responsible for determining who is eligible for continuation coverage.

CONVERSION OF COVERAGE

The Company allows You and Your Dependents to continue Your coverage under a Conversion Certificate of Coverage without evidence of insurability. You are not eligible for a Conversion Certificate of Coverage if You or Your Dependent(s) coverage under the Group Contract ends because: (a) You fail to pay any required contribution toward the cost of the dental benefits; or (b) the Company terminates Your coverage due to Member fraud in the use of dental services or facilities; or (c) You change Your residence to an area outside the State of Maryland. To convert coverage, You or Your Dependent(s) must apply in writing and pay the first three (3) month's Premium to the Company within thirty (30) days after Your Termination Date. Coverage under the Conversion Certificate of Coverage becomes effective on Your Termination Date for this Group Contract.

GENERAL PROVISIONS

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

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 of Maryland.

Privacy and Confidentiality of Dental Records

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

A statement describing Our policies and procedures for preserving the confidentiality of dental records is available and will be furnished to You upon request.

Rights of Company to Change Plan

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.

UNITED CONCORDIA

ENDORSEMENT
TO THE
DENTAL PLAN CERTIFICATE OF COVERAGE ("CERTIFICATE")

This Endorsement is effective on the Effective Date as stated in the Group Contract and attached to and made part of the Group Contract and the Certificate.

Eligibility and Enrollment

The **Eligibility and Enrollment – When Coverage Begins** section of the Certificate is hereby replaced in its entirety with the following:

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

In order to be a Member, You must meet the eligibility requirements of Your Group and this Group Contract. We must receive enrollment information for the Certificate Holder, enrolled Dependents, and Contractholder. Provided that We receive applicable Premium, coverage will begin on the date specified in the enrollment information We receive. Your Group will inform Certificate Holders of its eligibility requirements.

If You have already satisfied all eligibility requirements on the Group Contract Effective Date and Your enrollment information and applicable Premium is supplied to Us, Your coverage will begin on the Group Contract Effective Date.

If You are not eligible to be a Member on the Group Contract Effective Date, You must supply the required enrollment information on Yourself and any eligible Dependents, as specified in the Definitions section, within sixty (60) days of the date You meet the applicable eligibility requirements.

Coverage for Members enrolling after the Group Contract Effective Date 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.

Special Enrollment Periods - Enrollment Changes

After Your Effective Date, You can change Your enrollment during Your Group's open enrollment period. There are also Special Enrollment Periods when the Certificate Holder may add or remove Dependents or himself. These life change events include:

- birth of a child or grandchild;
- adoption of a child;
- court order of placement or custody of a child;
- loss of other coverage;

- marriage or other lawful union between two adults. .

If You enrolled, or are eligible through Your Group, to enroll a new Dependent or Yourself as a result of one of these events, You must supply the required enrollment change information within sixty (60) days of the date of the life change event. The Dependent must meet the definition of Dependent applicable to this Group Contract.

The Certificate Holder may also add or remove Dependents or change Plans for the reasons defined by and during the timeframes specified by applicable law or regulation.

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

Newly born children and grandchildren 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 sixty (60) days of birth who will be considered enrolled Dependents from the moment of birth. A minor for whom guardianship is granted by court or testamentary appointment shall be considered enrolled from the date of appointment. In order for coverage of newly born or adoptive children to continue beyond the first sixty (60) day period, if additional premium is required to cover a newly enrolled dependent child, the child's enrollment information must be provided to Us and the required Premium must be paid within the sixty (60) day period.

A child or grandchild of a Certificate Holder will not be denied the status of Dependent on the grounds that the child or grandchild: (a) was born out of wedlock; (b) is not claimed as a dependent on the Certificate Holder's federal income tax return; (c) does not reside with the Certificate Holder or in the Company's Service Area.

For an enrolled Dependent child who is mentally or physically incapacitated, proof of his/her reliance on You for support due to his/her condition must be supplied to Us within sixty (60) days after said Dependent attains the limiting age shown in the definition of Dependent. The Company will send notification to the Member at least ninety (90) days prior to the date the dependent child attains the limiting age. 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 dissolution of the union, reaching the limiting age or during open enrollment periods or specified in any applicable Late Entrant Rider to the Certificate of Coverage.

Late Enrollment

If You or Your Dependents are not enrolled within sixty (60) days of initial eligibility or during the Special Enrollment Period specified for a life change event, You or Your Dependents cannot enroll until the next Special Enrollment Period or open enrollment period conducted for Your Group. If You are required by court order to provide coverage for a Dependent child, You will be permitted to enroll the Dependent child without regard to enrollment season restrictions.

General

Except where specifically changed by this Endorsement, all of the terms and conditions of Your Plan's Certificate of Insurance continue to apply. In the event of a conflict between the provisions in this Endorsement and the Certificate of Insurance, this Endorsement shall control.

United Concordia Dental Plans, Inc.

Authorized Officer

APPEAL PROCEDURE

This Addendum is effective on the Effective Date stated in the Group Contract or Individual Conversion Dental Plan Contract. It is attached to and made part of the Certificate.

The following contains important information about how to file an Appeal. 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. You, Your Authorized Representative, or Your Health Care Provider may submit written comments, documents, records and other information relating to claims or Appeals. You may call Us at (888) 638-3384 or write to Us at P.O. Box 69420, Harrisburg PA 17106-9420. 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, Your Authorized Representative, or Your Health Care Provider.

Definitions

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

“Appeal " is a protest filed by You, Your Authorized Representative or a Health Care Provider with Us under Our internal appeal process regarding a Coverage Decision.

“Appeal Decision" is a final determination by Us that arises from an Appeal filed with Us under Our Appeal procedure regarding a Coverage Decision.

“Authorized Representative” is a person granted authority to act on Your behalf regarding a claim for benefit or an Appeal of a Coverage Decision. An assignment of benefits is not a grant of authority to act on Your behalf in pursuing a Coverage Decision.

“Claim for Benefits” is a request for a plan benefit or benefits by You in accordance with the Plan’s reasonable procedure for filing benefit claims, including Pre-service and Post-service Claims.

“Compelling Reason” means that a delay in receiving the health care service could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ or part, or the Member remaining seriously mentally ill with symptoms that cause the member to be in danger to self or others.

“Complaint" is a protest filed with the Commissioner involving a Coverage Decision.

“Coverage Decisions” is:

1. The initial determination by Us resulting in non-coverage of a dental care service;
2. The determination by Us that You are not eligible for coverage.
3. A determination by Us that results in a rescission of coverage.

The Company does not make utilization review determinations based on dental necessity or appropriateness. A Coverage Decision is not an Adverse Decision.

“Health Care Provider” is an individual who is licensed under the Health Occupations Article to provide health care services in the ordinary course of business or practices of a profession and is a treating provider of the Member or a Hospital.

“Hospital” means an institution that: has a group of at least five (5) physicians who are organized as a medical staff for the institution; maintains facilities to provide, under the supervision of the medical staff, diagnostic and treatment services for two (2) or more unrelated individuals; and admits or retains the individuals for overnight care.

“Pre-service Claim” is a Claim for Benefits under the Plan when the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

"Post-service Claim" ("Claim") is any Claim for Benefits under a group health plan that is not a Pre-service Claim.

PROCEDURE FOR PRE-SERVICE CLAIM

You, Your Health Care Provider, or Your Authorized Representative have 180 days from the date You or Your Authorized Representative received notice of the Coverage Decision to appeal the decision. To file an appeal, call the toll-free telephone number listed in Your Certificate of Coverage or on Your ID card.

The dentist advisor involved in the appeal will be different from and not a subordinate of the dentist advisor involved in the adverse determination on initial Claim for Benefits. We will provide You, Your Health Care Provider, or Your Authorized Representative with written or electronic notice of Our appeal decision within 30 days of the request to review the Adverse Benefit Determination. The notice of Our appeal decision will include the following:

a) The specific factual basis for Our decision in detailed and clear understandable language;
b) A reference to specific plan provisions on which the decision was based;
c) A statement that You, Your Health Care Provider, or Your Authorized Representative is entitled reasonable access to and copies of all relevant documents, records, and criteria. This includes an explanation of clinical judgment on which the decision was based and identification of the dental experts. All such information is available upon request and is free of charge.
d) A statement of Your, Your Health Care Provider's or Your Authorized Representative's right to bring a civil action under ERISA; and
e) a statement that the You, Your Health Care Provider, or Your Authorized Representative has a right to file an Appeal with Us. Our internal appeal process must be exhausted before You may file a Complaint with the Commissioner of Insurance.
f) a statement that You, Your Health Care Provider, or Your Authorized Representative 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. The Commissioner's address is as follows:

Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000 or 800-492-6116
Fax: 410-468-2270

g) a statement that the Health Advocacy Unit is available to assist You in both mediating and filing an Appeal under Our internal appeal process. You may contact the Health Advocacy Unit at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or toll-free: 877-261-8807
Fax: 410-576-6571
Email: heau@oag.state.md.us
Website: http://www.oag.state.md.us

Procedure for Post-Service Claim

You, Your Health Care Provider, or Your Authorized Representative may file an Appeal with Us upon the receipt of a Coverage Decision. To file an Appeal, telephone the toll-free number listed on Your ID card.

We will review the claim and notify You of Our decision within thirty (30) working days of the request for an Appeal. Within thirty (30) calendar days after a Coverage Decision has been made, We will send a written notice of the Coverage Decision to You or Your Authorized Representative, and the treating provider.

The notice of Coverage Decision from Us shall include:

1. the specific factual basis for Our decision in detailed and clear, understandable language.
2. a statement that the You, Your Health Care Provider, or Your Authorized Representative has a right to file an Appeal with Us. Our internal appeal process must be exhausted before You may file a Complaint with the Commissioner of Insurance.
3. a statement that You, Your Health Care Provider, or Your Authorized Representative 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. The Commissioner's address is as follows:

Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000 or 800-492-6116
Fax: 410-468-2270

4. a statement that the Health Advocacy Unit is available to assist You in both mediating and filing an Appeal under Our internal appeal process. You may contact the Health Advocacy Unit at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or toll-free: 877-261-8807
Fax: 410-576-6571
Email: heau@oag.state.md.us
Website: http://www.oag.state.md.us

Appeals Procedure

You may request reconsideration of a Coverage Decision by submitting a written Appeal to Us. We will reconsider the Coverage Decision. The Appeal will be reviewed and a final decision rendered. The final decision will be in writing to You or Your Authorized Representative and the Health Care Provider, within sixty (60) working days after the date on which the Appeal is filed.

The final decision will include a written notice of the Appeal decision. Written notice of the Appeal decision will be sent within thirty (30) calendar days of the Appeal decision to You or Your Authorized Representative and the Health Care Provider acting on Your behalf. The notice of the Appeal decision shall include the following:

a. the specific factual basis for Our decision in detailed and clear, understandable language.
b. that You, Your Health Care Provider, or Your Authorized Representative has a right to file a Complaint with the Commissioner within four (4) months after receipt of Our Appeal decision, including the contact information as indicated above.
c. a statement that You, Your Health Care Provider, or Your Authorized Representative 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. The Commissioner's address is as follows:

Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000 or 800-492-6116
Fax: 410-468-2270

d. a statement that the Health Advocacy Unit is available to assist You in both mediating and filing an Appeal under Our internal appeal process. You may contact the Health Advocacy Unit at:

Health Education and Advocacy Unit

Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or toll-free: 877-261-8807
Fax: 410-576-6571
Email: heau@oag.state.md.us
Website: http://www.oag.state.md.us

Issues other than Coverage Decisions

For issues such as Complaints about Your dental office, enrollment issues, or the general operation of the Plan, please contact the Maryland Insurance Administration at the address and telephone number listed above.

United Concordia Dental Plans, Inc.

Authorized Officer

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.

THE PROVIDER NETWORK AVAILABLE FOR MARYLAND INCLUDES

DC, DE, PA, VA

UNITED CONCORDIA

Concordia Plus Schedule of Benefits
Plan ST13

IMPORTANT INFORMATION ABOUT YOUR PLAN

- This Schedule of Benefits provides a listing of procedures covered by Your Plan. For procedures that require a Copayment, the amount to be paid is shown in the column titled "Member Pays $." You pay these Copayments to the dental office at the time of service.
- You must select a United Concordia Primary Dental Office (PDO) to receive Covered Services. Your PDO will perform the below procedures or refer You to a Specialty Care Dentist for further care. Treatment by an Out of Network Dentist is not covered, except as described in the Certificate of Coverage.
- Only procedures listed on this Schedule of Benefits are Covered Services. For services not listed (not covered), You are responsible for the full fee charged by the dentist. Procedure codes and member Copayments may be updated to meet American Dental Association (ADA) Current Dental Terminology (CDT) in accordance with national standards.
- For a complete description of Your Plan, please refer to the Certificate of Coverage and the Schedule of Exclusions and Limitations in addition to this Schedule of Benefits.
- If You have any questions about Your United Concordia Dental Plan, please call Our Customer Service Department toll free at **1-888-638-3384** or access Our Website at **www.unitedconcordia.com**.

ADA CODE	ADA DESCRIPTION	Member Pays $
	CLINICAL ORAL EVALUATIONS	
D0120	Periodic oral evaluation - established patient	0
D0140	Limited oral evaluation - problem focused	0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0
D0150	Comprehensive oral evaluation - new or established patient	0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	0
D0180	Comprehensive periodontal evaluation - new or established patient	0
	RADIOGRAPHS/DIAGNOSTIC IMAGING	
	(including interpretation)	
D0210	Intraoral - complete series of radiographic images	0
D0220	Intraoral - periapical first radiographic image	0
D0230	Intraoral - periapical each additional radiographic image	0
D0240	Intraoral - occlusal radiographic image	0
D0270	Bitewing - single radiographic image	0
D0272	Bitewings - two radiographic images	0
D0273	Bitewings - three radiographic images	0
D0274	Bitewings - four radiographic images	0
D0277	Vertical bitewings - 7 to 8 radiographic images	0
D0330	Panoramic radiographic image	0
D0340	Cephalometric radiographic image	0
	TESTS AND EXAMINATIONS	
D0460	Pulp vitality tests	0
D0470	Diagnostic casts	0
	DENTAL PROPHYLAXIS	
D1110	Prophylaxis - adult	0
D1120	Prophylaxis - child	0
	TOPICAL FLUORIDE TREATMENT	
	(off ce procedure)	
D1206	Topical application of fluoride varnish	0
D1208	Topical application of fluoride	0◆
	OTHER PREVENTIVE SERVICES	
D1330	Oral hygiene instructions	0
D1351	Sealant - per tooth	0
	SPACE MAINTENANCE	
	(passive appliances)	
D1510	Space maintainer - fixed - unilateral	0
D1515	Space maintainer - fixed - bilateral	0
D1520	Space maintainer - removable - unilateral	0
D1555	Removal of fixed space maintainer	0
	AMALGAM RESTORATIONS	
	(including polishing)	
D2140	Amalgam - one surface, primary or permanent	0
D2150	Amalgam - two surfaces, primary or permanent	0
D2160	Amalgam - three surfaces, primary or permanent	0
D2161	Amalgam - four or more surfaces, primary or permanent	0
	RESIN-BASED COMPOSITE RESTORATIONS - DIRECT	
D2330	Resin-based composite - one surface, anterior	0
D2331	Resin-based composite - two surfaces, anterior	0
D2332	Resin-based composite - three surfaces, anterior	0
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	70
D2391	Resin-based composite - one surface, posterior	40
D2392	Resin-based composite - two surfaces, posterior	60
D2393	Resin-based composite - three surfaces, posterior	72
D2394	Resin-based composite - four or more surfaces, posterior	84
	INLAY/ONLAY RESTORATIONS	
D2510	Inlay - metallic - one surface	60
D2520	Inlay - metallic - two surfaces	100
D2530	Inlay - metallic - three or more surfaces	120
D2542	Onlay - metallic - two surfaces	20
D2543	Onlay - metallic - three surfaces	30
D2544	Onlay - metallic - four or more surfaces	50
	CROWNS - SINGLE RESTORATIONS ONLY	
D2710	Crown - resin-based composite (indirect)	77
D2712	Crown - 3/4 resin-based composite (indirect)	86
D2740	Crown - porcelain/ceramic substrate	270
D2750	Crown - porcelain fused to high noble metal	276
D2751	Crown - porcelain fused to predominantly base metal	258
D2752	Crown - porcelain fused to noble metal	270
D2780	Crown - 3/4 cast high noble metal	228
D2781	Crown - 3/4 cast predominantly base metal	228
D2782	Crown - 3/4 cast noble metal	228
D2783	Crown - 3/4 porcelain/ceramic	228
D2790	Crown - full cast high noble metal	228

ADA CODE	ADA DESCRIPTION	Member Pays $
D2791	Crown - full cast predominantly base metal	258
D2792	Crown - full cast noble metal	264
D2794	Crown - titanium	290
	OTHER RESTORATIVE SERVICES	
D2910	Recement inlay, onlay, or partial coverage restoration	15
D2920	Recement crown	15
D2930	Prefabricated stainless steel crown - primary tooth	48
D2931	Prefabricated stainless steel crown - permanent tooth	56
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	48
D2940	Protective restoration	0
D2950	Core buildup, including any pins	100
D2951	Pin retention - per tooth, in addition to restoration	10
D2952	Post and core in addition to crown, indirectly fabricated	108
D2953	Each additional indirectly fabricated post - same tooth	45
D2954	Prefabricated post and core in addition to crown	108
D2957	Each additional prefrabricated post - same tooth	45
D2970	Temporary crown (fractured tooth)	65
D2971	Additional procedures to construct new crown under existing partial denture framework	25
	PULP CAPPING	
D3110	Pulp cap - direct (excluding final restoration)	0
D3120	Pulp cap - indirect (excluding final restoration)	0
	PULPOTOMY	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	25
D3221	Pulpal debridement, primary and permanent teeth	15
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	25
	ENDODONTIC THERAPY ON PRIMARY TEETH	
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	40
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	55
	ENDODONTIC THERAPY **(including treatment plan, clinical procedures and follow-up care)**	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	108
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	144
D3330	Endodontic therapy, molar (excluding final restoration)	198
	ENDODONTIC RETREATMENT	
D3346	Retreatment of previous root canal therapy - anterior	198
D3347	Retreatment of previous root canal therapy - bicuspid	234
D3348	Retreatment of previous root canal therapy - molar	288
	APICOECTOMY/PERIRADICULAR SERVICES	
D3410	Apicoectomy/periradicular surgery - anterior	107
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	107
D3425	Apicoectomy/periradicular surgery - molar (first root)	107
D3426	Apicoectomy/periradicular surgery (each additional root)	41
D3450	Root amputation - per root	50
	OTHER ENDODONTIC PROCEDURES	
D3920	Hemisection (including any root removal), not including root canal therapy	41
	SURGICAL SERVICES **(including usual postoperative care)**	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	125
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	50
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	0
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	135
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	54
D4245	Apically positioned flap	110
D4249	Clinical crown lengthening - hard tissue	105
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	210
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	110
D4263	Bone replacement graft - first site in quadrant	115
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	45
D4275	Soft tissue allograft	100
D4276	Combined connective tissue and double pedicle graft, per tooth	100
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in a graft	100
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	100
	NON-SURGICAL PERIODONTAL SERVICES	
D4320	Provisional splinting - intracoronal	40
D4321	Provisional splinting - extracoronal	40
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	60
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	16
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	50
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	100
	OTHER PERIODONTAL SERVICES	
D4910	Periodontal maintenance	30

ADA CODE	ADA DESCRIPTION	Member Pays $
	COMPLETE DENTURES	
	(including routine post-delivery care)	
D5110	Complete denture - maxillary	264
D5120	Complete denture - mandibular	264
D5130	Immediate denture - maxillary	288
D5140	Immediate denture - mandibular	288
	PARTIAL DENTURES	
	(including routine post-delivery care)	
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	174
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	174
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	270
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	270
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	350
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	350
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	78
	ADJUSTMENTS TO DENTURES	
D5410	Adjust complete denture - maxillary	7
D5411	Adjust complete denture - mandibular	7
D5421	Adjust partial denture - maxillary	7
D5422	Adjust partial denture - mandibular	7
	REPAIRS TO COMPLETE DENTURES	
D5510	Repair broken complete denture base	21
D5520	Replace missing or broken teeth - complete denture (each tooth)	28
	REPAIRS TO PARTIAL DENTURES	
D5610	Repair resin denture base	23
D5620	Repair cast framework	33
D5630	Repair or replace broken clasp	23
D5640	Replace broken teeth - per tooth	18
D5650	Add tooth to existing partial denture	23
D5660	Add clasp to existing partial denture	33
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	147
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	147
	DENTURE REBASE PROCEDURES	
D5710	Rebase complete maxillary denture	55
D5711	Rebase complete mandibular denture	55
D5720	Rebase maxillary partial denture	48
D5721	Rebase mandibular partial denture	48
	DENTURE RELINE PROCEDURES	
D5730	Reline complete maxillary denture (chairside)	40
D5731	Reline complete mandibular denture (chairside)	40
D5740	Reline maxillary partial denture (chairside)	40
D5741	Reline mandibular partial denture (chairside)	40
D5750	Reline complete maxillary denture (laboratory)	55
D5751	Reline complete mandibular denture (laboratory)	55
D5760	Reline maxillary partial denture (laboratory)	55
D5761	Reline mandibular partial denture (laboratory)	55
	INTERIM PROSTHESIS	
D5810	Interim complete denture (maxillary)	125
D5811	Interim complete denture (mandibular)	125
D5820	Interim partial denture (maxillary)	105
D5821	Interim partial denture (mandibular)	105
	OTHER REMOVABLE PROSTHETIC SERVICES	
D5850	Tissue conditioning, maxillary	25
D5851	Tissue conditioning, mandibular	25
	SURGICAL SERVICES	
D6010	Surgical placement of implant body: endosteal implant	1983
D6040	Surgical placement: eposteal implant	1983
D6050	Surgical placement: transosteal implant	1783
D6100	Implant removal, by report	172
	IMPLANT SUPPORTED PROSTHETICS	
D6058	Abutment supported porcelain/ceramic crown	1030
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	1030
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	970
D6061	Abutment supported porcelain fused to metal crown (noble metal)	985
D6062	Abutment supported cast metal crown (high noble metal)	1036
D6063	Abutment supported cast metal crown (predominantly base metal)	925
D6064	Abutment supported cast metal crown (noble metal)	985
D6065	Implant supported porcelain/ceramic crown	1030
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	1030
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	1036
D6094	Abutment supported crown – (titanium)	987
	OTHER IMPLANT SERVICES	
D6092	Recement implant/abutment supported crown	66
D6095	Repair implant abutment, by report	166
	FIXED PARTIAL DENTURE PONTICS	
D6205	Pontic - indirect resin based composite	290
D6210	Pontic - cast high noble metal	276
D6211	Pontic - cast predominantly base metal	258
D6212	Pontic - cast noble metal	264
D6214	Pontic - titanium	297
D6240	Pontic - porcelain fused to high noble metal	276
D6241	Pontic - porcelain fused to predominantly base metal	258
D6242	Pontic - porcelain fused to noble metal	264
D6245	Pontic - porcelain/ceramic	258
	FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS	
D6610	Onlay - cast high noble metal, two surfaces	150
D6612	Onlay - cast predominantly base metal, two surfaces	100
D6614	Onlay - cast noble metal, two surfaces	125
	FIXED PARTIAL DENTURE RETAINERS - CROWNS	
D6710	Crown - indirect resin based composite	290
D6740	Crown - porcelain/ceramic	258
D6750	Crown - porcelain fused to high noble metal	276
D6751	Crown - porcelain fused to predominantly base metal	258
D6752	Crown - porcelain fused to noble metal	264
D6790	Crown - full cast high noble metal	276
D6791	Crown - full cast predominantly base metal	258

ADA CODE	ADA DESCRIPTION	Member Pays $
D6792	Crown - full cast noble metal	264
D6794	Crown - titanium	290
	OTHER FIXED PARTIAL DENTURE SERVICES	
D6930	Recement fixed partial denture	17
	EXTRACTIONS	
	(includes local anesthesia, suturing, if needed, and routine postoperative care)	
D7111	Extraction, coronal remnants - deciduous tooth	8
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	20
	SURGICAL EXTRACTIONS	
	(includes local anesthesia, suturing, if needed, and routine postoperative care)	
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	27
D7220	Removal of impacted tooth - soft tissue	45
D7230	Removal of impacted tooth - partially bony	55
D7240	Removal of impacted tooth - completely bony	65
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	80
D7250	Surgical removal of residual tooth roots (cutting procedure)	35
D7251	Coronectomy - intentional partial tooth removal	65
	OTHER SURGICAL PROCEDURES	
D7280	Surgical access of an unerupted tooth	52
D7283	Placement of device to facilitate eruption of impacted tooth	13
D7285	Biopsy of oral tissue - hard (bone, tooth)	35
D7286	Biopsy of oral tissue - soft	28
D7288	Brush biopsy - transepithelial sample collection	45
	ALVEOLOPLASTY	
	(surgical preparation of ridge for dentures)	
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	23
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	30
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	30
	SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	60
	EXCISION OF BONE TISSUE	
D7471	Removal of lateral exostosis (maxilla or mandible)	60
D7472	Removal of torus palatinus	60
D7473	Removal of torus mandibularis	60
D7485	Surgical reduction of osseous tuberosity	60
	SURGICAL INCISION	
D7510	Incision and drainage of abscess - intraoral soft tissue	35
	OTHER REPAIR PROCEDURES	
D7960	Frenulectomy – also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	53
D7963	Frenuloplasty	27
D7972	Surgical reduction of fibrous tuberosity	60
	LIMITED ORTHODONTIC TREATMENT	
D8010	Limited orthodontic treatment of the primary dentition	380
D8020	Limited orthodontic treatment of the transitional dentition	405
D8030	Limited orthodontic treatment of the adolescent dentition	430
D8040	Limited orthodontic treatment of the adult dentition	455
	INTERCEPTIVE ORTHODONTIC TREATMENT	
D8050	Interceptive orthodontic treatment of the primary dentition	650
D8060	Interceptive orthodontic treatment of the transitional dentition	750
	COMPREHENSIVE ORTHODONTIC TREATMENT ✶	
D8070	Comprehensive orthodontic treatment of the transitional dentition	1,800
D8080	Comprehensive orthodontic treatment of the adolescent dentition	1,950
D8090	Comprehensive orthodontic treatment of the adult dentition	2,200
	MINOR TREATMENT TO CONTROL HARMFUL HABITS	
D8210	Removable appliance therapy	390
D8220	Fixed appliance therapy	370
	OTHER ORTHODONTIC SERVICES	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	150
✝	Orthodontic records fee	150
	UNCLASSIFIED TREATMENT	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	15
	ANESTHESIA	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	20
D9211	Regional block anesthesia	26
D9212	Trigeminal division block anesthesia	15
D9215	Local anesthesia in conjunction with operative or surgical procedures	18
D9220	Deep sedation/general anesthesia - first 30 minutes	205
D9221	Deep sedation/general anesthesia - each additional 15 minutes	103
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	205
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	100
	PROFESSIONAL CONSULTATION	
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	20
	PROFESSIONAL VISITS	
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	0
D9440	Office visit, after regularly scheduled hours	30
	DRUGS	
D9630	Other drugs and/or medicaments, by report	20
	MISCELLANEOUS SERVICES	
D9951	Occlusal adjustment - limited	20
D9952	Occlusal adjustment - complete	45

FOOTNOTES

◆ Two fluoride treatments per calendar year through age 18.

ADA CODE	ADA DESCRIPTION	Member Pays $	ADA CODE	ADA DESCRIPTION	Member Pays $

FOOTNOTES

★ Limited to a standard 24 month treatment.

✝ Please report under code D8999 “Unspecified orthodontic procedure, by report.” Records include all diagnostic procedures, such as cephalometric films, full mouth x-rays, models, and treatment plans.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

EXCLUSIONS

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

1. Not specifically listed in the Schedule of Benefits as a Covered Service.
2. Provided to Members by Out-of-Network Dentists except when immediate dental treatment is required as a result of a Dental Emergency occurring more than 50 miles from the Member's home.
3. That are necessary due to lack of cooperation with Primary Dental Office, or failure to comply with a professionally prescribed Treatment Plan.
4. Started or incurred prior to the Member's Effective Date of Coverage with the Company or started after the Termination Date of Coverage with the Company.
5. For consultations by a Specialty Care Dentist for services not specifically listed on the Schedule of Benefits as a Covered Service.
6. Services or supplies that are not deemed generally accepted standards of dental treatment.
7. That are the responsibility of Workers' Compensation or employer's liability insurance. The Company's benefits would be in excess to the third party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.
8. 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.
9. That restore tooth structure due to attrition, erosion or abrasion.
10. For periodontal splinting of teeth by any method.
11. For replacement of lost, missing, stolen or damaged prosthetic device or orthodontic appliance or for duplicate dentures, prosthetic devices or any duplicative device.
12. For replacement of existing dentures that are, or can be made serviceable.
13. For prosthetic reconstruction or other services which require a prosthodontist.
14. For assistant at surgery.
15. For elective procedures, including prophylactic extraction of third molars.
16. For congenital mouth malformations or skeletal imbalances, including, but not limited to, treatment related to cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery, including orthodontic treatment, and oral and maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging even if the condition requiring these services involves part of the body other than the mouth or teeth. This exclusion shall not apply to newly born children of Members as defined in the definition of Dependent.
17. For diagnostic services and treatment of jaw joint problems by any method. 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 that joint.
18. For implants, surgical insertion and/or removal of, and any appliances and/or crowns attached to implants.
19. For the following, which are not included as orthodontic benefits: retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient non-cooperation, repair of orthodontic appliances, replacement of lost or stolen appliances, special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders), myofunctional therapy, cases involving orthognathic surgery, extractions for orthodontic purposes, and treatment in excess of 24 months.
20. For active orthodontic treatment if started prior to a Member's effective date.
21. For prescription or nonprescription drugs, home care items, vitamins or dietary supplements.
22. For hospitalization and associated costs for rendering services in a hospital.
23. For house or hospital calls for dental services.
24. For any dental or medical services performed by a physician and/or services which benefits are otherwise provided under a health care plan of the employer.
25. Which are Cosmetic in nature as determined by the Company, including, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures.

26. For broken appointments.

27. 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.

LIMITATIONS

The following services, **if listed on the Schedule of Benefits**, will be subject to limitations as set forth below. A "benefit accumulation year," as used in this Schedule, means the time period under the Group Contract during which the Plan's Covered Services accrue and is either a calendar year (12 months beginning in January and ending in December) or a contract year (12 months beginning with the Effective Date of the Group Contract).

1. Bitewing x-rays – one set(s) per six consecutive months through age 13, and *one* set(s) of bitewing x-rays per 12 consecutive months for age 14 and older.

2. Panoramic or full mouth x-rays – one per three-year period.

3. Prophylaxis – two per benefit accumulation year.

4. Routine prophylaxis and periodontal maintenance procedures are limited to no more than two per benefit accumulation year

5. Sealants – one per tooth per three year(s) through age 15 on permanent first and second molars.

6. Fluoride treatment – two per benefit accumulation year through age 18.

7. Space maintainers only eligible for Members through age 18 when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop.

8. Restorations, crowns, inlays and onlays – covered only if necessary to treat diseased or fractured teeth.

9. Crowns, bridges, inlays, onlays, buildups, post and cores – one per tooth in a five-year period.

10. Crown lengthening – one per tooth per lifetime.

11. Referral for specialty care is limited to orthodontics, oral surgery, periodontics, endodontics, and pediatric dentists.

    This limitation does not apply if the service was provided as a result of a standing or non-network referral as described in the Certificate of Coverage.

12. Coverage for referral to a pediatric Specialty Care Dentist ends on a Member's seventh birthday.

13. Pupal therapy – through age five on primary anterior teeth and through age 11 on primary posterior teeth.

14. Root canal treatment – one per tooth per lifetime.

15. Root canal retreatment – one per tooth per lifetime.

16. Periodontal scaling and root planing – one per 24 consecutive month period per area of the mouth.

17. Surgical periodontal procedures – one per 24 consecutive month period per area of the mouth.

18. Full and partial dentures – one per arch in a five-*year* period.

19. Denture relining, rebasing or adjustments – are included in the denture charges if provided within six months of insertion by the same dentist.

20. Subsequent denture relining or rebasing – limited to one every 36 consecutive months thereafter.

21. Oral surgery services are limited to surgical exposure of teeth, removal of teeth, preparation of the mouth for dentures, removal of tooth generated cysts up to 1.25cm, frenectomy and crown lengthening.

22. Wisdom teeth (third molars) extracted for Members under age 15 or over age 30 are not eligible for payment in the absence of specific pathology.

23. If for any reason orthodontic services are terminated or coverage under the Company is terminated before completion of the approved orthodontic treatment, the responsibility of the Company will cease 60 days after termination if paid monthly or the later of 60 days after termination or the end of the quarter in progress if paid quarterly. This extension of orthodontic payment does not apply if coverage was terminated due to failure of the individual to pay required Premium, fraud, or material misrepresentation by the individual, or if succeeding coverage is provided by another health plan and the cost to the individual is less than or equal to the cost to the individual of coverage during the extension and there is no interruption of benefits.

24. Orthodontic treatment – not eligible for Members over age 18 unless listed otherwise in the Member's Schedule of Benefits.

25. Comprehensive orthodontic treatment plan – one per lifetime.

26. In the case of a Dental Emergency involving pain or a condition requiring immediate treatment, the Plan covers necessary diagnostic and therapeutic dental procedures administered by an Out-of-Network Dentist up to the difference between the Out-of-Network Dentist's charge and the Member Copayment up to a maximum of $50 for each emergency visit.

27. Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bony or complete bony impactions).

28. An Alternative Benefit Provision (ABP) may be applied by the Primary Dental Office 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 and Schedule of Exclusions and Limitations

Maternity Dental Benefit

This Rider is effective on January 1, 2014 and is attached to and made a part of the Schedules of Benefits and Schedule of Exclusions and Limitations.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS:

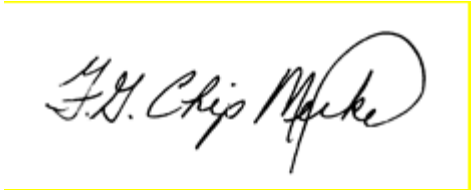
The following limitation is substituted for the limitation on prophylaxis in the Schedule of Exclusions and Limitations:

Prophylaxis – **two** per benefit accumulation year, unless otherwise specified in the Schedule of Benefits. One additional Prophylaxis in a twelve consecutive month period for Members under the care of a medical professional for pregnancy.

SCHEDULE OF BENEFITS:

Member Copayments on the Schedule of Benefits shall apply to the additional prophylaxis provided to a Member under the care of a medical professional for pregnancy.

UNITED CONCORDIA DENTAL PLANS, INC.



Authorized Officer