EVIDENCE OF COVERAGE

DENTAL PLAN
THE STATE OF MARYLAND
Concordia FLEX

ADMINISTRATIVE INFORMATION

Plan Name: The State of Maryland

Informal Plan Name: Concordia **FLEX**

Employer/Plan Sponsor: The State of Maryland

Employer/Plan Sponsor Address: 301 West Preston Street
Suite 510
Baltimore, MD 21201

Employer/Plan Sponsor Telephone Number: (410) 767-4775

Plan Sponsor Tax Identification No.:

Plan Number: 907569000, 907569001, 907569002, 907569004

Type of Plan: Group Dental

Type of Administration: Third Party Administration

Plan Administrator: Anne Timmons
*Note: Your Plan Administrator is responsible for the Administration of your Plan. United Concordia Companies, Inc. is a Claims Administrator only.

Claims Administrator: United Concordia Companies, Inc.
4401 Deer Path Road
Harrisburg, PA 17110
Telephone number: (888) 638-3384

Agent for Service of Legal Process: N/A

Funding Medium: The Plan is funded by employer/employee contributions. United Concordia is a Claims Administrator only, and is not liable for the payment of Plan Benefits.

Trustee(s): N/A

Plan Year: January 1 through December 31

INTRODUCTION

The State of Maryland (the "Company") sponsors the Concordia Flex ("Plan") for the benefit of its eligible employees [and the eligible employees of its subsidiaries and affiliates] (collectively, “the Group”) listed in the "Plan Information" section at the end of this document.

Dental benefits are one of the welfare benefits that the Plan provides. For convenience, all employers whose employees are eligible are included in the reference term "Company"; however, United Concordia as Plan Sponsor controls the Plan.

The document, together with the attached Schedule of Benefits issued by United Concordia Companies, Inc. ("United Concordia" or “We” or “Us” or “Our”) constitutes the EVIDENCE OF COVERAGE ("EOC") for the Plan's dental benefits. United Concordia administers the Plan participants’ claims for dental benefits.

This section of the EOC provides required general information applicable to all Plan benefits as well as some specific information about the dental benefits.

The Schedule of Benefits, which is part of the EOC, provides important detailed information about covered claims, exclusions and limitations, the rules for submitting claims and similar guidance.

The EOC includes important rules regarding employee eligibility, dependent eligibility, coverage elections, changes of elections and similar guidance.

This EOC is written in an easy-to-understand way to explain the Group Dental Plan (“the Plan”) and provide information on the Plan which you may need in the future. If you have any questions after reading this EOC, contact the Company (the Plan Administrator) or United Concordia (the Claims Administrator) at the address and telephone number under the Administrative Information section at the beginning of this document.

The Plan is intended to provide dental benefits for eligible employees and their covered dependents.

United Concordia does not make eligibility determinations. Eligibility determinations are normally made by the Plan Administrator.

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

You are eligible to enroll in the Plan if you meet the eligibility requirements of Your Group. We must receive enrollment information for the Plan participant and enrolled dependents. Coverage will begin on the date specified in the enrollment information We receive. Your Group will inform Plan participants of its eligibility requirements.

If you have already satisfied all eligibility requirements and your enrollment information is supplied to Us, your coverage will begin on either the first or the 16th based on the pay period in which the first deduction is taken.

If you are not eligible to be a Plan participant at the start of the Plan Year, you must supply the required enrollment information on yourself and any eligible dependentswithin sixty (60) days of the date you meet all applicable eligibility requirements.

Coverage for Plan participants and dependents enrolling after the start of the Plan Year will begin on the date specified in the enrollment information supplied to Us.

The Company is not liable to pay benefits for any services started prior to a Plan participant'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 Plan participant's effective date are the liability of the Plan participant, his/her prior insurance carrier or prior benefit plan.

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 Plan participant 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
- divorce

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 eligibility criteria specified by the Plan Sponsor for participation in this Plan.

Plan participants 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 date specified in the enrollment information provided to Us.

Newly born children and grandchildren of a Plan participant 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, the child's enrollment information must be provided to Us within the sixty (60) day period.

A child or grandchild of a Plan participant 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 Plan participant's federal income tax return; (c) does not reside with the Plan participant 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 for dependents specified by the Plan Sponsor. The Company will send notification to the Plan participant at least ninety (90) days prior to the date the dependent child attains the limiting age.

Such evidence will be required at intervals based on information provided by the dependent's physician, but no more frequently than annually.

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

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.

CHANGE IN BENEFIT ELECTIONS

Generally, your Plan elections must stay in effect for the entire Plan Year. There are certain limited circumstances under which you are permitted to change your annual election. The following events are changes that if consistent with the requested change in your benefit election will permit you to change your benefit election during a Plan Year.

- You get married or divorced
- You have a child or adopt a child
- Your spouse or a child dies
- Your spouse commences or terminates employment
- Your or your spouse's employment status changes from full-time to part-time or from part-time to full-time
- You or your spouse take an unpaid leave of absence

- There is a significant change in the dental coverage that is provided by your spouse's employer.

HOW THE DENTAL PLAN WORKS

Choice of Dentist

You may choose **any** licensed dentist for services to be covered by the Plan. However, you will reduce your out-of-pocket costs if you choose a United Concordia participating dentist. Participating dentists accept the Plan's allowance as payment in full for covered benefits. Your out-of-pocket cost will be limited to any applicable coinsurance, deductibles or amounts exceeding the program maximum. Participating dentists will also complete and send claims directly to United Concordia.

If you go to a dentist who is not a United Concordia's participating dentist, you may have to pay the dentist at the time of service. You will also have to pay the difference between the dentist's charge and the amount that the Plan allows, in addition to any coinsurance or deductible. You may have to submit the claim and wait for United Concordia (the Claims Administrator) to reimburse you.

To find a participating dentist, visit *Find a Dentist* on the United Concordia's website at *www.unitedconcordia.com* or telephone the United Concordiaat the toll-free number under the Administrative Information section of this document.

When you visit the dental office, let your dentist know that you are covered under a United Concordia program. If your dentist has questions about your eligibility or benefits, instruct the office to call the United Concordia at the number under the Administrative Information section of this document or visit *Dental Inquiry* on the United Concordia's website at *www.unitedconcordia.com.*

Claims Submission and Payment

Upon completion of treatment, a claim form needs to be filed with United Concordia. If you visit a United Concordia participating dentist, the dental office will submit claims forms for you and your dependents. United Concordia will pay covered benefits directly to the participating dentist. Both you and the dentist will be notified if your claim is denied or reduced.

If you do not receive treatment from a participating dentist, you may have to complete and send a claim form to the United Concordia in the event the dental office will not do this for you. Send the claim form or predetermination to the address provided by United Concordia. Be sure to include the patient's name, date of birth, the employee's contract ID number, patient's relationship to employee, the employee's name and address, and the name and policy number of a second insurer if the patient is covered by another dental plan. Your dentist should complete the treatment and provider information or supply an itemized receipt for you to attach to the claim form. United Concordia will send payment to you if covered services are provided by a non-participating dentist and you do not indicate on the claim that you wish payment to be sent to the dentist. You will receive an explanation of benefits.

Should you have any questions concerning your coverage, eligibility or a specific claim, contact United Concordia at the address and telephone number on the Administrative Information page of this document or log onto *My Dental Benefits* at *www.unitedconcordia.com.*

EOC (revision 10/22/14)

Predetermination of Benefits

A predetermination is a review in advance of treatment by the United Concordia to determine eligibility and coverage for planned services in accordance with the Schedule of Benefits and the Plan allowance. Predetermination is not required to receive a benefit for any service under the Plan; however, predetermination is recommended for extensive, more costly treatment. A predetermination gives you and your dentist an estimate of what your coverage is and how much your share of the cost will be for the treatment being considered.

To have services predetermined, you or your dentist should submit a claim form showing the planned procedures but leaving out the dates of services. Be sure to sign the predetermination request. Substantiating material such as radiographs and periodontal charting may be requested by United Concordia to estimate benefits. United Concordia will determine benefits payable, taking into account exclusions and limitations and alternate treatment options based upon accepted standards of dental practice. You and your provider, if participating in United Concordia's network, will receive an explanation of the estimated benefits.

When the services are performed, simply have your dentist call United Concordia at the telephone number on the Administrative Information page of this document, or fill in the dates of service for the completed procedures on the predetermination notification and re-submit it to United Concordia for processing. Any predetermination amount estimated by United Concordia is subject to continued eligibility of the patient. United Concordia may also make adjustments at the time of final payment to correct any mathematical errors, apply coordination of benefits, and comply with the member's Plan in effect and remaining program maximum dollars at date of service.

BENEFITS

Schedule of Benefits

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

- the dental service groupings covered, shown with a "Plan Pays" percentage
- the percentage of the Plan allowance that the Plan will pay
- any waiting periods applicable to the services
- any deductibles you must pay before any benefits will be paid by the Plan, and the services excluded from the deductibles
- any maximums for services for a given period of time; for example, annual for most services and lifetime for orthodontics.

If the service grouping is shown on the Schedule of Benefits as not covered or at "Plan Pays -- 0%", no benefits will be paid for the dental procedures in that grouping. Service groupings shown with "Plan Pays" percentages of less than 100% require you to pay a portion of the cost. For example, if the Plan pays 80%, your share is 20% of the Plan allowance.

The general descriptions below explain the service groupings on the Schedule of Benefits. The descriptions are not all-inclusive – they include only the most common dental procedures in a service grouping. Specific dental procedures may be shifted among groupings or may not be covered depending on your Employer's choice of Plan. Check the Schedule of Benefits at the back of this document to see which groupings are covered and have your provider call United Concordia to verify

coverage of specific dental procedures. Services covered on the Schedule of Benefits are also subject to the Alternate Treatment Provision following this section and the Schedule of Limitations and Exclusions attached to this document.

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

Alternate Treatment Provision

There are often several ways to treat a dental condition. For example, a filling or a crown can restore a tooth, or a fixed bridge or a partial denture can replace missing teeth. An Alternate Benefit Provision (ABP) will be applied if a dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The Plan will pay for the less costly professionally acceptable procedure. The ABP does not commit you to the less costly treatment; however, if you and your dentist choose the more expensive treatment, you are responsible for the additional charges beyond those allowed for the less expensive procedure under the ABP.

Limitations and Exclusions

Services covered by the Plan as indicated on the Schedule of Benefits are subject to frequency or age limitations detailed on the attached Schedules of Limitations and Exclusions. No benefits will be provided for services, supplies or charges detailed under the Exclusions on the attached Schedule of Limitations and Exclusions.

COORDINATION OF BENEFITS

If you or your dependents are covered by any other dental benefits plan and receive a service covered by this Plan and the other, 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 other 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. Total benefits paid by this Plan and the other plans will not exceed one hundred percent of the charges or contracted reimbursement.

1. The following words and phrases regarding the Coordination of Benefits ("COB") provision are defined as set forth below:

A) **Allowable Amount** is the Plan's allowance for items of expense, when the care is covered at least in part by one or more Plans covering the individual for whom the claim is made.

B) **Claim Determination Period** means a Plan 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** shall be any of the following which provides dental benefits, or services, for the following: Group insurance or group type coverage, whether insured or uninsured. This includes prepayment groups. 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 this Plan shall be considered to be the amount of benefits paid by United Concordia. United Concordia will be fully discharged from liability to the extent of such payment under this provision.

3 In order to determine which plan is primary, the Plan will use the following rules.

A) The other plan does not have a provision similar to this one, then that plan shall be primary.

B) Non-Dependent/Dependent -- If both plans have COB provisions, the plan covering the individual as a primary insured is determined before those of the plan which covers the person as a dependent.

C) Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a dependent child when the parents are not separated or divorced are:

1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

D) Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as dependent child of divorced or separated parents, benefits for the child are determined in this order:
1) First, the plan of the parent with custody of the child.
2) Then, the plan of the spouse of the parent with the custody of the child; and
3) Finally, the plan of the parent not having custody of the child.
4) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan.
5) If the specific terms of the court decree state that the parents shall 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 shall follow the order of benefit determination rules outlined in Section C.3. above, titled Dependent Child/Parents Not Separated or Divorced.

E) Active/Inactive Member
1) For actively employed individuals and their spouses over the age of 65 who are covered by Medicare, the plan shall be primary.
2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.

F) If none of these rules apply, then the contract which has continuously covered the individual for a longer period of time shall be primary.

G) The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a plan participant or a dependent.

4. Right to Receive and Release Needed Information -- Certain facts are needed to apply these COB rules. United Concordia has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Any health information furnished to a third party will be released in accordance with federal law. Each person claiming benefits under This Plan must give any facts needed to pay the claim.

5. Facility of Payment -- A payment made under another plan may include an amount which should have been paid under This Plan. If it does, United Concordia 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 United Concordia 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 United Concordia.

6. Right of Recovery -- If the payment made by United Concordia is more than it should have paid under this COB provision, United Concordia 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. Plan participants are required to assist United Concordia to implement this section.

SUBROGATION OF BENEFITS

In the event any payment is made under the Plan, the Plan shall be subrogated and shall succeed to the rights of any Participant against any other plan, person or entity for recovery of dental care expenses for which such other plan, person or entity is liable. All amounts so recovered, by settlement, judgment or otherwise, shall be paid to the Plan, for ultimate disposition thereunder, which may include payment to the Employer. Participants shall furnish such information, execute and deliver such assignment documents and other instruments, and take whatever steps are necessary to secure the rights of the Plan and the Employer. Participants shall take no action to prejudice the rights and interests of the Plan or the Employer hereunder.

NON-ALIENATION OF BENEFITS

No right or benefit provided for under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge the same shall be void. However, this Section shall not be construed to prevent a Participant from directing the Plan to pay expenses directly to a provider of services or products if those expenses are otherwise reimbursable to the Participant under Plan. In such event, the Plan shall be relieved of all further responsibility with respect to that particular expense.

TERMINATION OF COVERAGE

Your coverage and/or your dependents' coverage will end on the date provided by the Plan Administrator or the date United Concordia receives the termination notice when the following events occur:

- Your termination of employment with the Plan Administrator.
- Your failure to satisfy the Plan's eligibility requirements.
- Your dependents cease to be dependents as defined by the Plan.
- Your disenrollment from the Plan.
- Your failure to immediately return to work after an approved leave of absence with the Plan Administrator during which you were entitled to receive coverage under the Plan.
- Your fraudulent use of dental services or facilities.
- Your failure to timely pay any required contributions under this Plan.

If your coverage or your dependent's is terminated as described above, coverage for completion of a dental procedure, other than orthodontics, that requires two or more dental office visits on separate days will extend for ninety (90) days after termination. The procedure must be started prior to your termination date. This extension of benefits does not apply if the termination is due to nonpayment of premiums or fraud on your part. In the case of orthodontic treatment, if covered under the Plan, your coverage will extend through the end of the month of termination.

If the Plan is terminated, your coverage will end on the date of the Plan's termination.

COORDINATION WITH OTHER LAWS

Family & Medical Leave Act. A Participant on an Employer approved leave of absence under the Family & Medical leave Act shall continue to participate in the Plan in accordance with the requirements of such act.

Qualified Medical Child Support Order. To the extent required by ERISA Section 609(a), the Plan shall comply with the terms of any medical child support order determined by the Plan Administrator to constitute a Qualified Medical Child Support Order. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator named in the EOC.

COBRA Continuation Coverage. Notwithstanding the termination provisions of the Plan described above, if the Employer normally employed 20 or more employees on a typical business day during the preceding calendar year, continuation coverage shall be provided under the Plan in accordance with ERISA Section 601 through 608, code Section 4980B, and Title XXII of the Public Health Services Act ("COBRA Continuation Coverage"). The terms of such COBRA Continuation Coverage are described below:

a) COBRA Continuation Coverage shall be offered under the following circumstances ("qualifying events") if participation under the Plan ordinarily would terminate as a result of such circumstances:
   (1) the Participant's termination of employment (other than by reason of such Participant's gross misconduct) or reduction of work hours to a level that would exclude him and his family from the Plan;
   (2) the Participant's divorce or legal separation; (3) death of the Participant; (4) the Participant's entitlement of Medicare benefits; (5) a dependent child ceasing to qualify as a "dependent" eligible for coverage under the terms of the Plan; or (6) the commencement by the Employer on or after July 1, 1986 of a Title 11 bankruptcy proceeding. (Item (6) affects only retired Participants, their Spouses and Dependents).

b) COBRA Continuation Coverage shall be offered only to the Participant and/or his Spouse and his Dependents who were covered under the Plan on the day before the qualifying event occurred and who lose coverage under the Plan on account of the qualifying event ("qualified beneficiaries"). The qualified beneficiary shall be entitled to elect only the type of coverage he was receiving under the Plan at the time of the qualifying event. The right to elect core coverage, i.e., basic hospitalization and major medical coverage, shall be offered separately. Non-core coverage will not be offered separately from core coverage under the Contract.

c) In the case of qualifying event described in (a)(2) or (5) above, the Participant or his family must notify the Employer of the qualifying event within 60 days of the date of the event. In all other cases, the Employer shall be deemed to be notified of the qualifying event. Within

14 days of such notification, the Employer shall provide the Participant and/or his family with a notice of the right to elect COBRA continuation coverage.

d) The Participant, his Spouse, or his Dependent may elect COBRA Continuation Coverage within 60 days of the later of the date of the qualifying event, or the date to the notice form the Employer to qualified beneficiary. Each qualified beneficiary may make a separate election for COBRA continuation coverage. If an election is made within the 60-day period, the Plan shall permit payment for COBRA continuation coverage during the period preceding such election to be made not less than 45 days after the date of the election. If the election to continue coverage is not made within the above 60-day period, then no further opportunity to continue coverage will be extended to the Participant, his Spouse or his Dependents. COBRA Continuation Coverage is not conditioned upon evidence of insurability.

e) In the case of (a) (1) above, COBRA Continuation Coverage may continue for up to 18 months. If, within the first sixty (60) days of continuation coverage, it is determined that the qualified beneficiary was disabled (under Title II or XV of the Social Security Act), continuation coverage may continue an additional 11 months, or a total of 29 months. To qualify for the additional 11 months, the Employer must be notified of the disability within 60 days after the date of determination. Such additional coverage will cease if the disability terminates. Therefore, the Employer must be notified within 30 days of the date of any final determination that the disability no longer exists. In the case of (a)(2) through (5), coverage may continue for up to 36 months. In this case of (a)(6), coverage may continue (1) until the death of the retired Participant or of any qualified beneficiary who, on the day before the qualifying event, was a surviving spouse or dependent child of the Participant, for up to 36 months after the death of the Participant. Notwithstanding the continuation periods specified above, COBRA Continuation Coverage shall terminate with respect to a qualified beneficiary upon the earlier of:

i The date on which the Employer ceases to provide any group dental plan to any employee;

ii The date upon which coverage under the plan ceases as a result of failure to make timely premium payments as required by (f) below; premium payments shall be considered timely if made within 30 days of the due date; however, coverage shall be terminated retroactively as of the due date if payments are not received within 30 days; non-sufficient fund checks are not payment;

iii The date upon which the qualified beneficiary becomes covered under any other group dental plan (as an employee or otherwise) if such plan does not contain an exclusion or limitation with respect to any preexisting condition of such qualified beneficiary; or

iv The date upon which the qualified beneficiary (other than a qualified beneficiary described in (a) (6) above) becomes entitled to Medicare benefits. In the event of multiple qualifying events, the maximum required continuation period is 36 months.

f) The Plan shall require payment of a premium for any period of COBRA Continuation Coverage in

an amount that shall not exceed 102% of the cost to the Plan for such period of coverage for active Participants with respect to who a qualifying event has not occurred. The Cost to the Plan for coverage shall be determined for a period of 12 months selected by the Plan and shall be determined before the beginning of such period. The qualified beneficiary may elect to make any required premium payments in monthly installments. If the COBRA continuation period is extended from 18 months to 29 months due to disability as provided in (e) above, the premium for the additional 11 months of coverage shall be an amount not to exceed 150% of the cost to the Plan for such coverage, rather than 102% of such cost.

PLAN AMENDMENT

The Plan Sponsor reserves the right, at any time, to amend or terminate the Plan or amend or eliminate benefits under the Plan for any reason. All changes will be communicated in writing. If the Plan is discontinued, benefits, if any, will be paid for all charges incurred for covered services prior to the termination date.

APPEALS

Internal Appeals: If a healthcare claim you will be incurring or have incurred has been denied, you may contact your Plan using the contact information on your Explanation of Benefits (EOB) form or on the back of your insurance identification card for information on filing an internal appeal. This must be done within 180 days (6 months) from the date the claim was denied. If your Plan upholds the denial, you have the right to request an external review (external appeal) of the denial by the Maryland Insurance Administration.

External Appeals: For a claim denied because the service was considered not medically necessary, medically inappropriate or is considered cosmetic or experimental or investigational, you, your representative or a healthcare provider acting on your behalf, may be entitled to request an independent, external review within 120 days (4 months) from the date the claim was denied. If you request an external review, the Maryland Insurance Administration (MIA) will review and provide a final, written determination. If MIA decides to overturn the insurance carrier's decision, we will instruct the insurance carrier to provide coverage or payment for your healthcare item or service. For questions on your rights to external review contact:

Maryland Insurance Administration
Attn: Appeals and Grievance Unit
200 St. Paul Place,
Suite 2700 Baltimore,
Maryland 21202
Telephone: (410)
468-2000 Toll-free:
1-800-492-6116
Facsimile: (410) 468-
2270 TTY: 1-800-
735-2258

If a claim is denied because the service was not a covered service and is not eligible for an independent, external review, but you still disagree with the denial, you may contact the Employee Benefits Division for additional review at the following:

Employee Benefits Division
Attn: Adverse Determinations
301 West Preston Street, Room 510
Baltimore, MD 21201
Telephone: (410) 767-4775
Toll-free: 1-800-307-8283
Facsimile: (410) 333-7104

Urgent Care Request: If your situation meets the definition of urgent care under the law, a review of your claim will be conducted as expeditiously as possible. An urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe your situation is urgent, you may request an expedited review process by contacting your plan at the phone number listed on the back of your insurance identification card, or you may contact the Maryland Insurance Administration (see above).

Assistance resources: For questions about your rights or for assistance in filing an appeal, you can contact:

Office of Health Insurance Consumer Assistance Employee Benefits
Security Administration
Maryland Office of Attorney General
1-866-444-3272
Health Education and Advocacy Unit
200 St Paul Place, 16th Floor
Baltimore, MD 21202
Telephone: (877) 261-8807 OR
http://www.oag.state.md.us/Consumer/HEAU.htm heau@ioag.state.md.us

Schedule of Benefits

Group Name: The State of Maryland
Group Number: 907569000, 907569001, 907569002
907569004 ***Effective Date: January 1, 2015***

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

Deductibles & Maximums

- *$50 per PlanYear Deductible per person (excluding Class I & Orthodontics) not to exceed $150 per family*
- *$2500 per PlanYear maximum per person*
- *$2000 Lifetime maximum per person for Orthodontics*

Biological children, stepchildren and adopted children are covered through end of the month in which they turn 26. Other child dependents – grandchildren, step grandchildren, legal wards, and other child relatives – are covered until the end of the month in which they turn 25.

All services on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations.

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

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – DPPO Plan

Except as specifically provided in the Schedule of Benefits or Riders attached to this Evidence of Coverage, no coverage will be provided for services, supplies or charges:

1. Not specifically listed as a Covered Service on the Schedule of Benefits and those listed as not covered on the Schedule of Benefits.
2. Which are necessary due to patient neglect, lack of cooperation with the treating dentist or failure to comply with a professionally prescribed Treatment Plan.
3. Started prior to the participant's Effective Date or after the Termination Date of coverage with the Company, including, but not limited to multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures.
4. Services or supplies that are not deemed generally accepted standards of dental treatment.
5. For hospitalization costs.
6. For prescription or non-prescription drugs, vitamins, or dietary supplements.
7. Administration of nitrous oxide, general anesthesia and i.v. sedation, unless specifically indicated on the Schedule of Benefits.
8. Which are cosmetic in nature as determined by the Company, including, but not limited to bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures.
9. Elective procedures including but not limited to the prophylactic extraction of third molars.
10. For the following which are not included as orthodontic benefits - retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient neglect, or repair of an orthodontic appliance.
11. For congenital mouth malformations or skeletal imbalances, including, but not limited to treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment.
12. For dental implants including placement and restoration of implants unless specifically covered under a rider to this Evidence of Coverage.
13. For oral or maxillofacial services including but not limited to associated hospital, facility, anesthesia, and radiographic imaging even if the condition requiring these services involves part of the body other than the mouth or teeth.
14. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under a Rider to this Evidence of Coverage. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
15. For treatment of fractures and dislocations of the jaw.
16. For treatment of malignancies or neoplasms.
17. Services and/or appliances that alter the vertical dimension, including but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
18. Replacement of lost, stolen or damaged prosthetic or orthodontic appliances.
19. For broken appointments.
20. For house or hospital calls for dental services.

21. Replacement of existing crowns, onlays, bridges and dentures that are or can be made serviceable.
22. Preventive restorations in the absence of dental disease.
23. Periodontal splinting of teeth by any method.
24. For duplicate dentures, prosthetic devices or any other duplicative device.
25. For services determined to be furnished as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Health Occupations Article. Prohibited referrals are referrals of a patient to an entity in which the referring dentist, or the dentist's immediate family: (a) owns a beneficial interest; or (b) has a compensation arrangement. The dentist's immediate family includes the spouse, child, child's spouse, parent, spouse's parent, sibling, or sibling's spouse of the dentist, or that dentist in combination.
26. For which in the absence of insurance the participant would incur no charge.
27. For plaque control programs, oral hygiene, and dietary instructions.
28. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the armed forces of any country or international authority.
28. For training and/or appliance to correct or control harmful habits, including, but not limited to, muscle training therapy (myofunctional therapy).
29. For any claims submitted to the Company by the participant or on behalf of the participant in excess of twelve (12) months after the date of service. Failure to furnish the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the required time, if the claim is furnished as soon as reasonably possible and, except in the absence of legal capacity of the participant, not later than 1 year from the time claim is otherwise required.
30. Which are not Dentally Necessary as determined by the Company.

LIMITATIONS -– DPPO Plan

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

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

Rider to Schedule of Benefits

Preventive Incentive®

This Rider is effective on January 1, 2015 and is attached to and made a part of the Schedule of Benefits.

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

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

Rider to Schedule of Benefits and Schedule of Exclusions and Limitations

Implantology

This Rider is effective on January 1, 2015 and is attached to and made a part of the Schedule of Benefits and Schedule of Exclusions and Limitations.

SCHEDULE OF BENEFITS

The Company will pay implantology benefits for eligible Plan participants and enrolled dependents for the following Covered Services equal to 50% of the Maximum Allowable Charge as determined by United Concordia.

Implantology Services

Surgical Services

D6010 surgical placement of implant body: endosteal implant
D6011 second stage implant surgery.
D6013 surgical placement of mini implant; claims review includes a review of radiographs and an indication of how the implants will be restored
D6040 surgical placement: eposteal implant
D6050 surgical placement: transosteal implant
D6100 implant removal, by report
D6101 debridement of a periimplant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure
D6102 debridement and osseous contouring of a periimplant defect or defects surrounding a single implant, and includes surface cleaning of the exposed implant surfaces including flap entry and closure
D6103 bone graft for repair of peri-implant defect – does not include flap entry and closure; does not include placement of a barrier membrane or biologic materials to aid in osseous regeneration
D6104 bone graft at time of implant placement.

Supporting Structures

D6055 connecting bar – implant supported or abutment
D6056 prefabricated abutment – includes modification and placement
D6057 custom fabricated abutment – includes placement

Implant/Abutment Supported Removable Dentures

D6110 implant/abutment supported removable denture for edentulous arch – maxillary
D6111 implant /abutment supported removable denture for edentulous arch – mandibular
D6112 implant/abutment supported removable denture for partially edentulous arch – maxillary
D6113 implant/abutment supported removable denture for partially edentulous arch – mandibular

Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)

D6114 implant/abutment supported fixed denture for edentulous arch – maxillary
D6115 implant/abutment supported fixed denture for edentulous arch – mandibular

D6116 implant/abutment supported fixed denture for partially edentulous arch – maxillary
D6117 implant/abutment supported fixed denture for partially edentulous arch – mandibular

Single Crowns, Abutment Supported

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

Single Crowns, Implant Supported

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

Fixed Partial Denture, Abutment Supported

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

Fixed Partial Denture, Implant Supported

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

Other Repair Procedures

D7950 osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report
D7951 sinus augmentation with bone or bone substitutes via a lateral open approach
D7952 sinus augmentation via a vertical approach
D7953 bone replacement graft for ridge preservation – per site

Deductible(s)

No Deductible will be applied to implantology services.

Maximum(s)

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

Waiting Period(s)

No Waiting Period will be applied to implantology services.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

The Schedule of Exclusions and Limitations is amended as follows:

Exclusions

Any exclusions relating to implantology services are deleted.

Limitations

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

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

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

Implantology services are limited to one (1) per tooth per lifetime.
Implantology services are limited to participants age eighteen (18) and older.