UNITED CONCORDIA

UNITED CONCORDIA

4401 Deer Path Road
Harrisburg, PA 17110

Dental Plan
Certificate of Insurance

Network Plan

STATE OF MARYLAND PPO
842843000, 842843001, 842843002, 842843004, 842843006, 842843007, 842843008, 842843009
JULY 1, 2013

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

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

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

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

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

9804-C (07/05)

CERTIFICATE OF INSURANCE

INTRODUCTION

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

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

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

(866) 638-3384

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

www.unitedconcordia.com

Claim forms should be sent to:

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

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Attached:

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

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

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

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

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

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

Enrollment Changes

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

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

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

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

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

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

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

Late Enrollment

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

HOW THE DENTAL PLAN WORKS

Choice of Provider

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

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

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

Claims Submission

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

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

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

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

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

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

Predetermination

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

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

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

BENEFITS

Schedule of Benefits

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

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

Your Out-of-Pocket Costs

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

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

Services

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

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

Exclusions and Limitations

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

Payment of Benefits

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

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

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

Overpayments

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

Coordination of Benefits (COB)

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

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

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

F) **Plan** means this document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.

2. The fair value of services provided by the Company will be considered to be the amount of benefits paid by the Company. The Company will be fully discharged from liability to the extent of such payment under this provision.

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

A) If the other plan does not have a provision similar to this one, then that plan will be primary.
B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.
C) Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:
    1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
    2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
    3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
    4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
D) Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:
    1) First, the plan of the parent with custody of the child.
    2) Then, the plan of the spouse of the parent with the custody of the child; and
    3) Finally, the plan of the parent not having custody of the child.
    4) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
    5) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 3-C) above, titled Dependent Child/Parents Not Separated or Divorced.
E) Active/Inactive Member
    1) For actively employed Members and their spouses over the age of 65 who are covered by Medicare, the plan will be primary.
    2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.
F) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary.
G) The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a Member or a Dependent.

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

5. Facility of Payment -- A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Company may pay the amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan, and the Company will not pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the services prepaid by the Company.

6. Right of Recovery -- If the payment made by the Company is more than it should have paid under this COB provision, the Company may recover the excess from one or more of the following: (1) persons it has paid or for whom it has paid; or (2) insurance companies; or (3) other organization. Members are required to assist the Company to implement this section.

Workers' Compensation

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

Review of a Benefit Determination

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

TERMINATION -- WHEN COVERAGE ENDS

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

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

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

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

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

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

CONTINUATION COVERAGE

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

GENERAL PROVISIONS

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

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

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

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

COLORADO ADDENDUM TO CERTIFICATE

APPEAL PROCEDURE - - ADVERSE DETERMINATION

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

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

DEFINITIONS

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

"Adverse determination" is a denial, reduction, or termination of or failure to make payment (in whole or in part) based on a determination of availability of care or a determination that a health care service has been reviewed and, based upon the information provided, does not meet Our requirements for dental necessity, determined to be experimental or investigational, appropriateness, health care setting, level of care or effectiveness. An Adverse determination also includes denial for a benefit excluded by the Plan for which You are able to present evidence from a Colorado licensed dentist that there is a reasonable basis that the contractual exclusion does not apply to the denied benefit.

"Clinical Peer" is a physician or other health care professional who holds a non-restricted license in any state in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

"Designated representative" is a person, including the treating health care professional or person authorized by You, and to whom You have given express written consent to represent You; or a person authorized by law to provide substituted consent for You, including but not limited to a guardian, agent under power of attorney, or a proxy to act on Your behalf regarding a claim for benefit or an appeal of an adverse benefit determination. An assignment of benefits is not a grant of authority to act on Your behalf in pursuing and appealing a benefit determination.

"Grievance" means a circumstance regarded as a cause for protest, including the protest of an Adverse determination.

"Relevant" A document, record, or other information will be considered "**relevant**" if it:

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

INTERNAL REVIEW OF AN ADVERSE DETERMINATION

You or Your Designated representative is entitled to contact Us for assistance in initiating an internal appeal of an Adverse determination. You or Your Designated representative are entitled to receive upon request and free of charge, reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical rationale and clinical review criteria on which the decision was based and identification of the dental experts.

First Level Internal Review

Within 180 days after the date of a notice of an Adverse determination You may file a request for a first level appeal of an Adverse determination. Upon receipt of an oral or written request for First Level Internal Appeal of an Adverse benefit determination, We will conduct a complete investigation and notify You and Your provider in writing. A first level appeal will be evaluated by a dentist, who shall consult with an appropriate Clinical Peer, unless the reviewing dentist is a Clinical Peer. The dentist and/ or Clinical Peers shall not have been involved in the initial adverse determination. A review takes into consideration all documents and records regarding the initial request for services You submitted, if the benefit was denied due to a contractual exclusion evidence from a dentist that there was a reasonable denial basis that the exclusion doesn't apply. You or Your Designated representative do not have the right to attend, but You may submit written comments, documents, records or other material You want considered. You are entitled to receive from the Plan free of charge reasonable access to and copies of all documents, records or other information relevant to the request for benefits. You may identify providers to whom We will send a copy of the review decision. You may submit written comments, documents, records and other material relating to the request for benefits for the reviewers to consider. We will notify You and Your provider in writing or electronically of Our decision 30 days after receipt of the request. The 30 day time period will begin on the date the request for review is filed with Us without regard to whether all of the information necessary to make the determination accompanies the filing. Our written or electronic decision will include:

a) the name, title and qualifying credentials of the dentist evaluating the appeal, and the qualifying credentials of the clinical peers with whom the dentist consults
b) a statement of Our understanding of the reason for Your request for an appeal
c) Our decision in clear terms and the clinical rationale in detail
d) the evidence used as the basis for Our decision and the clinical review criteria
e) a statement of Your right to file an appeal for a Voluntary Second Level Internal Appeal and the process for submitting that request in writing
f) a statement of Your right to bypass the Voluntary Second Level Internal Appeal and proceed to an External Review
g) to file an appeal, call the toll-free number listed in Your Certificate of Insurance or on Your ID card.

If We do not meet the first level internal review timeline, then the internal process is deemed exhausted and You may request an external review.

Voluntary Second Level Review

If You are dissatisfied with the First Level Review decision, within 30 days of receipt of a notice of an Adverse determination, You or Your Designated representative may request a Voluntary Second Level Review. You have the right to appear in person or by telephone conference at the review meeting before a dental professional selected by the Plan.

The review will be conducted by a dentist with the expertise appropriate to your case and not previously involved in the first level review and does not have a direct interest in the outcome of the review.

A review meeting will be scheduled and conducted within 60 days of receipt of a request from You or Your Designated representative for a voluntary second level review. We will notify You or Your Designated representative in writing at least 20 days in advance of the review date. You will be notified in writing of the reviewer's decision. You may identify providers to whom You want Us to send a copy of the review decision.

Upon Your request, We will provide You with all relevant information that is not confidential or privileged under state or federal law. You have the right to attend the second level review, present Your case in person or in writing, submit supporting material both before and at the review meeting, ask questions of the dental professional prior to the hearing and at the hearing, and be assisted by a Designated representative.

If We decide to have an attorney present to represent Our interests, We will notify You at least 20 days in advance of the review that an attorney will be present and that You may wish to obtain legal representation. Within 7 days in advance of the review, You should inform Us if You intend to have an attorney present to represent Your interests.

A health care professional, after private deliberation, will issue a written decision to You within 7 days of completing the review meeting.

If We do not meet the voluntary second level internal review timeline, then the internal process is deemed exhausted and You may request an external review.

INDEPENDENT EXTERNAL REVIEW

Within four (4) months after receipt of the Plan's decision following a first level internal review or sixty (60) days after receipt of the voluntary second level review of an Adverse determination, You or Your Designated representative may file a request for an independent external review with Us. There is no minimum dollar amount for a claim to qualify for an external review. The cost of the independent external review will be paid by the Plan. All requests must be made in writing and must include a completed external review request form specified by the Colorado Division of Insurance. The request must also include a signed consent form authorizing Us to disclose Your protected health information, including Your dental records pertinent to the external review. You or Your Designated representative may include new information, if significantly different from information provided or considered during the internal review process.

After the Plan receives Your request for an independent external review, the Plan will contact the Colorado Division of Insurance within two (2) working days to have an independent external review entity assigned to Your review. The Colorado Division of Insurance will assign an independent external review entity with two (2) working days from receipt of the external review request. The Plan will notify You in writing which certified independent external review entity was selected. In addition to providing the name of the independent review entity, We will, within one (1) working day, provide their contact information and instructions as to how You can provide the Division of Insurance documentation regarding the Adverse determination. If a conflict of interest is identified, You must report it to the Division of Insurance within two (2) working days. The Division of Insurance must then assign a new independent review entity within one (1) working day of receipt of the documentation.

We will send all the information and documentation considered in making the Adverse determination within five (5) working days from receipt of the notice to the independent review entity. If the independent review entity requests additional information from Us, we will provide the information requested within five (5) working days. Upon request, We will provide You with copies of the information supplied to the independent review entity that is not confidential or privileged under state or federal law. If We fail to provide the required information to the independent review entity, the external review process will be terminated and Our decision will be reversed. You may submit additional information to the independent review entity within five (5) working days of receiving notice of the independent review entity's identity. Following the five (5) days, the independent review entity is not required to consider new information You have provided. Within one (1) working day of the independent review entity receiving information from You or Your provider, they must forward the information to Us.

Upon receipt of the additional information forwarded from the independent review entity, We can reconsider the Adverse determination. If the decision is made to reverse the Adverse determination, We will notify You, Your Designated representative, the independent review entity, and the Colorado Division of Insurance electronically, by fax, or by telephone within one (1) working day, followed by a written confirmation.

Within forty-five (45) days after the date of receipt of the request for a standard external review, the independent external review entity will notify You, Your Designated representative, Your dentists and Us of its decision. An independent external review decision is binding on You and the Plan except to the extent that other remedies are available under Federal or state law. If the independent review entity reverses Our Adverse determination, We must approve coverage within five (5) working days. Subsequent to Our approval,, We will provide written notice of the approval to You or Your Designated representative within one (1) working day.

COLORADO STATE LAW PROVISIONS ADDENDUM

TO

CERTIFICATE OF INSURANCE

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

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

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

(a) until the end of the month the child reaches the limiting age of 26; or

(b) to any age beyond the limiting age listed above if the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

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

Dependent also includes a Designated Beneficiary if the employer elects to cover a Designated Beneficiary as a dependent.

The following definitions are added to the "DEFINITIONS" section of the Certificate only for Members of Policyholders headquartered in Colorado:

Designated Beneficiary – is a person who has entered into a designated beneficiary agreement.

Designated Beneficiary Agreement - is an agreement recognized by Colorado law entered into by two people for the purpose of designating each person as the beneficiary of the other person and for ensuring that each person has certain rights and financial protections based on the designation.

The Enrollment Changes subsection of the "ELIGIBILITY AND ENROLLMENT – WHEN COVERAGE BEGINS" section of the Certificate is deleted and the following substituted only for Members of Policyholders headquartered in Colorado. The subsection remains the same for Members of Policyholders headquartered outside of Colorado.

Enrollment Changes

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

- birth of a child;
- adoption of a child;
- court order of placement or custody of a child;
- marriage of the Certificate Holder;
- domestic partnership of the Certificate Holder;
- Designated Beneficiary Agreement.

To enroll a new Dependent as a result of one of these events, You must notify Your Group and supply the required enrollment change information within 30 days of the date You acquired the Dependent. The Dependent must meet the requirements detailed in the definition of Dependent in the Definitions section of this Certificate.

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

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

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

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

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

The following subsection(s) "Notice of Claim", "Claim Forms", "Proof of Loss", "Time Payment of Claims", "Payment of Claims" and "Dental Exams" are added to the "HOW THE DENTAL PLAN WORKS" section of the Certificate:

Notice Of Claim

Written notice of claim must be given to the Company within 20 days after the occurrence or after the event on which the claim is based. Notice given by or on behalf of the Member to the Company, at the address referenced in the introductory section of this Certificate**,** which contains sufficient information to identify the Member, shall be deemed notice to the Company, if it was not reasonably possible to give written notice within the 20 day period.

Claim Forms

The Company, upon receipt of a notice of claim, will furnish to the Policyholder for delivery to such person such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after the Company received notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

Proof of Loss

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

Time Payment of Claims

All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid no later than 30 days from receipt of due written proof of such loss. The Company may extend this 30-day period by no more than 15 days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Company. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid quarterly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims

All benefits under this policy shall be payable to the Participating Dentist if Your Plan is a Network Plan or the Certificate Holder, or to his designated beneficiary or beneficiaries, or to his estate, except that if the Member is a minor or otherwise is not competent to give a valid release, such benefits may be made payable to his custodial parent, guardian, or other person actually supporting him. All or a portion of any indemnities provided by this Policy on account of dental services may, at the option of the Company and unless the Member requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the dental office rendering such services.

Dental Exams

The Company at its own expense shall have the right and opportunity to examine You when and as often as it may reasonably be required during the pendency of a claim hereunder.

The “Review of a Benefit Determination” subsection of the “BENEFITS” section of the Certificate is deleted and the following substituted:

If You are not satisfied with the Plan’s benefit, You or Your Designated representative can take further steps regarding Your claim. You or Your Designated representative may file an appeal with Us upon receipt of an adverse determination by calling Our Customer Service Department at the toll-free number listed in the Introduction section of this Certificate or on Your ID card.

The following provision is added to the "CONTINUATION COVERAGE" section of the Certificate:

Continuation of coverage shall be extended to those Certificate Holders and their Dependent(s) whose employment is terminated from the Policyholder, if the Group Policy continues to remain in effect for active employees of the Policyholder. Such continuation of coverage shall be subject to the following provisions:

(1) the employee's eligibility to receive coverage has ended for any reason other than discontinuance of the Group Policy in its entirety or with respect to an insured class;
(2) any Premium or contribution required from or on behalf of the employee has been paid to the termination date; and
(3) the employee has been continuously insured under the Group Policy, or under any Group Policy providing similar benefits which it replaces, for at least 6 months immediately prior to termination.

The following provision and subsection entitled "Legal Actions" are added to the "GENERAL PROVISIONS" section(s) of the Certificate:

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

Legal Actions
No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of 60 days after claims have been filed in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of 3 years after the time a claim is required to be filed.

UNITED CONCORDIA

ADDENDUM

TO

GROUP POLICY AND CERTIFICATE OF INSURANCE

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

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

> The Company uses Maximum Allowable Charge schedules to determine claim payments. Payment is the lesser of the dentist's submitted charge or the Maximum Allowable Charge.
>
> Maximum Allowable Charges for Covered Services are determined by geographical area of the dental office. The Maximum Allowable Charges in the geographical area of the dental office are used to calculate the Company's payment on claims. Maximum Allowable Charges are reviewed periodically and adjusted as appropriate to reflect increased dentist fees within the geographical areas. Participating Dentists accept their contracted Maximum Allowable Charges as payment in full for Covered Services.

FEDERAL LAW SUPPLEMENT

TO

CERTIFICATE OF INSURANCE

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

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

(1) You or your dependent either loses eligibility for coverage under Medicaid or the Children's Health Insurance Program ("CHIP"); or

(2) You or your dependent becomes eligible for premium assistance from Medicaid or CHIP allowing enrollment in a benefit program.

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

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

United Concordia Life and Health Insurance Company
a wholly owned subsidiary of United Concordia Companies, Inc.
4401 Deer Path Road, Harrisburg, PA 17110

Concordia PPO sm

Group Name: State of Maryland PPO
Group Number: 842843000, 842843001, 842843002, 842843004, 842843006, 842843007, 842843008, 842843009
Effective Date: July 1, 2013

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

Deductibles & Maximums

- *$25 per Contract Year Deductible per Member (excluding Class I & Orthodontics) not to exceed $75 per family*
- *$750 per Contract Year Maximum per Member*
- *$2000 Lifetime Maximum per Member for Orthodontics*

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

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

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – DPPO Plan

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

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

28. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the national guard or in the armed forces of any country or international authority.

29. For training and/or appliance to correct or control harmful habits, including, but not limited to, muscle training therapy (myofunctional therapy).

30. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service. Failure to furnish the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the required time, if the claim is furnished as soon as reasonably possible and, except in the absence of legal capacity of the Member, not later than 1 year from the time claim is otherwise required.

31. Which are not Dentally Necessary as determined by the Company.

32. For prosthetic services including but not limited to full or partial dentures or fixed bridges, if such services replace one or more teeth missing prior to the Member's eligibility under the Company.

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

LIMITATIONS -– DPPO 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 Members under the care of a medical professional during pregnancy.
6. Fluoride treatment – two per benefit accumulation period.
7. Space maintainers - only eligible for Members through age eighteen when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not develop.
8. Prefabricated stainless steel crowns - one per tooth per lifetime for age fourteen years and younger.
9. Crown lengthening - one per tooth per lifetime.
10. Periodontal maintenance following active periodontal therapy – two per twelve months in addition to routine prophylaxis.
11. Periodontal scaling and root planing - one per two year period per area of the mouth.
12. Replacement of an existing:

- filling with another filling – not within 12 months of placement.
- single crown with another single crown - not within 5 years of placement.
- inlay with another inlay, or with a single crown or onlay – not within 5 years of placement.
- onlay with another onlay, or with a single crown - not within 5 years of placement.
- buildup with another buildup - not within 5 years of placement.
- post and core with another post and core - not within 5 years of placement.

13. Replacement of natural tooth/teeth in an arch – not within 5 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.

United Concordia

Rider to Schedule of Benefits

Preventive Incentive®

This Rider is effective on July 1, 2013 and is attached to and made a part of the Schedule of Benefits.

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

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

United Concordia Life and Health Insurance Company

Authorized Officer

United Concordia

Rider to Schedule of Benefits and Schedule of Exclusions and Limitations

Implantology

This Rider is effective on July 1, 2013 and is attached to and made a part of the Schedule of Benefits and Schedule of Exclusions and Limitations.

SCHEDULE OF BENEFITS

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

Implantology Services

Surgical Services

D6010 surgical placement of implant body: endosteal implant
D6040 surgical placement: eposteal implant
D6050 surgical placement: transosteal implant
D6100 implant removal, by report
D6101 debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure.
D6102 debridement and osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure.
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

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

Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)

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

Single Crowns, Abutment Supported

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

Single Crowns, Implant Supported

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

Fixed Partial Denture, Abutment Supported

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

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
D7953 bone replacement graft for ridge preservation – per site

Deductible(s)

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

Maximum(s)

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

Waiting Period(s)

No Waiting Period will be applied to implantology services.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

The Schedule of Exclusions and Limitations is amended as follows:

Exclusions

Any exclusions relating to implantology services are deleted.

Limitations

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

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

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

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

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

D6101 debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure are limited to once per lifetime for ages 18 and older.

D6102 debridement and osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure are limited to once per lifetime for ages 18 and older.

D6104 bone graft at time of implant placement are limited to once per lifetime for ages 18 and older.

UNITED CONCORDIA LIFE AND HEALTH INSURANCE COMPANY

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Authorized Officer