UNITED CONCORDIA

UNITED CONCORDIA INSURANCE COMPANY

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

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call United Concordia Insurance Company's toll-free number for information or to make a complaint at:

1-888-638-3384

You may contact Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact United Concordia Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de United Concordia Insurance Company's para informacion o para someter una queja al:

1-888-638-3384

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con la United Concordia Insurance Company primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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

TX9804-C (03/07)

CERTIFICATE OF INSURANCE

INTRODUCTION

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

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

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

(888) 638-3384

For general information, Contracting 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
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 employee 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".

Contracting Dentist - A dentist who has executed a contracting dentist agreement with the Company or an affiliate of the Company, under which he/she agrees to provide Covered Services under this Plan.

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 as determined by a dentist to either establish or maintain a patient's dental health. Such determinations are based on the professional diagnostic judgment of the dentist and the standards of care that prevail in the professional community. The determination as to when a dental service is necessary shall be made by the dentist in accordance with guidelines established by the Company. In the event of any conflict of opinion between the dentist and the Company as to when a dental service or procedure is Dentally Necessary, the issue shall be submitted for a second opinion as described in the "SECOND OPINION and ALTERNATIVE TREATMENT" portion of this Certificate.

Dependent(s*)* - Certificate Holder's spouse or domestic life partner as defined by the Policyholder and/or state law and any unmarried child, stepchild or grandchild 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) 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.

Eligible Persons-Those employees or dependents who are eligible to participate in the Plan under the eligibility requirements described in the Policy.

Employee- An employee of the Group or Policyholder.

Enrollment/Change Form - A form provided by the Company which the Employee completes to enroll. Such information may be transmitted from the Group to the Company using any agreed upon form of written or electronic media.

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.

Insurance Coverage- Insurance for Covered Services described in a Certificate of Insurance made a part of the Group Policy, including all Certificate Riders, Schedules and modifications and endorsements to such Certificate.

Insured Person(s)- Employee(s) and his/her Dependent(s) who have met the Group eligibility requirements and are Insured under the Policy.

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.

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

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.

Standard of Reimbursement – The standard the Plan uses to determine payment for Covered Service(s) performed by {a Contracting or a Non-Contracting Dentist or a dentist}. The Standard of Reimbursement is shown on the Schedule of Benefits.

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.

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
- addition of a grandchild
- court order of placement or custody
- marriage or other life change event defined by Your Group.

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 child, adoptive child or grandchild, 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 children, adoptive children or grandchildren 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.

Eligible Dependents will also include any children of the eligible Employee's dependent child, if those children are dependents of the Employee for income tax purposes.

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 31 days after said Dependent attains the limiting age shown in the definition of Dependent. Such evidence will be requested based on information provided by the Member's physician but no more frequently than annually.

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

No person can enroll as a Dependent if they are also enrolling as an Employee (such as a spouse). No person can be an eligible Dependent for more than one eligible Employee.

IT IS THE ENROLLED EMPLOYEE'S RESPONSIBILITY TO KEEP THE COMPANY ADVISED OF CHANGES THAT AFFECT EACH DEPENDENT'S STATUS.

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.

Voluntary Disenrollment

If You chose to drop Your coverage or Your Dependents' coverage under the Plan at any time during the contract year other than at open enrollment, you will not be permitted to enroll yourself or your dependents at a later time unless you supply proof of loss of coverage under another dental plan. The loss of coverage must be due to a valid life change event such as death, divorce or change in employment status of spouse. If you supply such proof, you will be permitted to re-enroll at the next open enrollment period. You will be considered a new enrollee with respect to application of any Waiting Periods or benefit level changes shown on the Schedule of Benefits.

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 Contracting Dentist, You may limit Your out-of-pocket cost. Contracting Dentists agree by contract to accept Maximum Allowable Charges as payment in full for Covered Services. Contracting dentists also complete and send claims directly to Us for processing. To find a Contracting 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 Contracting 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 *Dental Inquiry* 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. Contracting 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 Contracting 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.

Claim Forms

The Company 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 insurer 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

In the case of claim for any loss, written proof of such loss must be furnished to the Company within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it was not reasonably possible to furnish such 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 of the claimant, later than one year from the time proof is otherwise required.

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 Standard of Reimbursement shown on Your Schedule of Benefits. 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 Dental Inquiry 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.

Second Opinion and Alternative Treatment

We, upon notification, will determine (in consultation with the attending dentist) whether or not a dental service or procedure is Dentally Necessary. If the attending dentist does not agree with the decision of our Dental Advisor, the case will be automatically reviewed at a higher level. This secondary review, or peer review, will be done by a dentist who is also an advisor to Us (Dental Director). If the attending dentist or You wish to contest the informal reviews, a formal review can be initiated by writing an appeal to Our Quality Assurance department within thirty (30) days after the initial decision. An advisory board will then review Your case based on recommendations of the ADA and other nationally recognized standards.

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

Payment of Benefits

If You have treatment performed by a Contracting Dentist, We will pay covered benefits directly to the Contracting 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. The Standard of Reimbursement for Covered Services shown on Your Schedule of Benefits will be based on the Maximum Allowable Charge the treating Contracting Dentist has contracted to accept.

If You receive treatment from a Non-Contracting 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 Standard of Reimbursement for Covered Services shown on Your Schedule of Benefits. 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.

Acceptance or Rejection of Claims

a) The Company will notify a Claimant in writing of the acceptance or rejection of the claim not later than the 15th business day after the date the Company receives all items, statements and forms required by the Company, in order to secure final proof of loss.
b) If Company rejects the claim, the notice will state the reasons for the rejection.
c) If Company is unable to accept or reject the claim within the period specified by Subsection (a) of this section, Company will notify the claimant, not later than the date specified under Subsection (a), as applicable. The notice provided will give the reasons Company needs additional time.
d) Not later than the 45th day after the date Company notifies a claimant under Subsection (c) of this section, Company will accept or reject the claim.
e) Except as otherwise provided, if Company delays payment of a claim following its receipt of all items, statements and forms reasonably requested and required, for more than 60 days, Company will pay damages and other items as provided for under "DAMAGES" below.
f) If it is determined as a result of arbitration or litigation that a claim received by Company is invalid and therefore should not be paid, the requirements of Subsection (e) of this section shall not apply in such case.

Damages

In all cases where a claim is made pursuant to the Policy and Company is liable therefore and is not in compliance with the requirements of this Section, Company shall be liable to pay the Policy Holder making the claim, in addition to the amount of the claim, 18 % per annum of the amount of such claim as damages, together with reasonable attorney fees. If a suit is filed, attorney fees shall be taxed as part of the costs in the case.

Time Payment of Claims

All benefits payable under the Policy other than benefits for loss of time shall be payable not more than 60 days after receipt of proof, that, subject to due proof of loss, all accrued benefits payable under the Policy for loss of time shall be paid not less frequently than monthly during the continuance of the period for which the Company is liable, and that any balance remaining unpaid at the termination of such period shall be paid as soon as possible after receipt of such proof.

(a) Reimbursement shall be made to the Texas Department of Human Resources for the actual cost of medical expenses the department pays through medical assistance for an Insured Person by the Policy if the Insured Person is entitled to payment for the medical expenses by the insurance Policy.

(b) Payment of benefits shall be made on behalf of a child to the person who is not an Employee of the Group if a court order providing for the managing conservator of the child has been issued by a court competent jurisdiction in this or any other state. However, any requirements imposed on the managing conservator of the child shall not apply in the cases of any unpaid medical bill for which a valid assignment of benefits has been exercised in accordance with policy provisions or otherwise, nor to claims submitted by the Employee where the Employee has paid any portion of a medical bill that would be covered under the terms of the policy.

    Before a person who is not an Employee of the Group is entitled to be paid benefits under this Section, the person must submit to the Company with the claim application written notice that the person:
    1) is the managing conservator of the child on whose behalf the claim is made; and
    2) submit a certified copy of a court order establishing the person as managing conservator or other evidence designated by rule of the State Board of Insurance that the person qualifies to be paid the benefits as provided herein.

(c) Benefits paid on behalf of the child or children under the Policy must be paid to the Texas Department of Human Services after written notice to the Company at the Company's home office, if:
    (1) the parent who purchased the policy or who is an Employee of the Group is:
        a) a possessory conservator of the child under an order issued by a court in this state or is not entitled to possession of or access to the child; and
        b) is required by court order or court-approved agreement to pay child support;
    (2) the Texas Department of Human Services is paying benefits on behalf of the child; and
    (3) the Company is notified through an attachment to the claim for insurance benefits when the claim is first submitted to the Company that the benefits must be paid directly to the Texas Department of Human Services.

Dental Exams

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

Time Limit on Certain Defenses

If after two years from the date of issue of this Certificate no misstatements, except fraudulent misstatements, made by the Insured Person in the application for such Certificate shall be used to void the Certificate or to deny a claim for loss incurred or disability as defined in the Certificate commencing after the expiration of such two year period.

Legal Actions

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the Policy and that no such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the Policy.

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)

Applicability:
This Coordination of Benefits (COB) provision applies to This Plan when an Insured Person has health care coverage under more than one Plan. **Plan** and **This Plan** are defined below. [This provision will apply for the duration of Your employment with the Group.]

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

a) Shall not be reduced when This Plan determines its benefits before another plan; but
b) May be reduced when another plan determines its benefits first.

Definitions:
Plan is any of these which provided benefits or services for, or because of, dental care or treatment:

1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident type coverage.
2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, or the United States Social Security Act, as amended).

Each contract or other arrangement for coverage under (a) or (b) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

This Plan is the part of the Policy that provides benefits for health care expenses.

Primary Plan/Secondary Plan: The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

Allowable Amount means a Dentally Necessary, Reasonable and Customary item of expense for dental care; when the item of expense is covered at least in part by one or more plans covering the Insured for whom claim is made.

When a plan provides benefits in the form of services, the reasonable cash value of each service is rendered will be considered both an Allowable Amount and a benefit paid.

When benefits are reduced under a Primary Plan because an Insured Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Amount. Examples of such provisions are those related to second surgical opinions or precertification of admissions or services.

Claim Determination Period means a Policy Year. However, it does not include any part of a year during which an Insured Person has no coverage under This Plan.

Order of Benefit Determination Rules:
When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless;

A) The other plan has rules coordinating its benefits with those of This Plan; and
B) Both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other plan.

This Plan determines its order of benefits using the first of the following rules which applies:

Non-Dependent/Dependent
The benefits of the Plan which covered the Insured as an Employee, member or subscriber are determined before those of the plan which covers the Insured Person as a Dependent; except if the Insured Person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

1) Secondary to the plan covering the Insured Person as a Dependent, and
2) Primary to the plan covering the Insured Person as other than a Dependent (e.g., a retired employee),

Then the benefits of the plan covering the Insured person as a Dependent are determined before those of the plan covering that Insured Person as other than a Dependent.

Dependent Child/Parents Not Separated or Divorced
Except as stated in Paragraph (c) below, when This Plan and another plan cover the same child as a dependent of different persons, called parents, the rules for the order of benefits for a Dependent child when the parents are not separated or divorced are as follows:

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;

However, if the other plan does to have the rule described in (1) immediately above, but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

Dependent Child/Separated or Divorced Parents
If two or more plans cover an Insured Person as a 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.

However, 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**. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has the actual knowledge.

A. Joint Custody
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 (b) above, title Dependent Child/Parents Not Separated or Divorced.

B. Active/Inactive Employee

The benefits of a plan which covers an Insured Person as an Employee who is neither laid off nor retired are determined before those of a plan which covers that Insured Person as a laid off or retired Employee. The same would hold true if an Insured Person is a Dependent of a Person covered as a retiree and an Employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (e) is ignored.

C. Continuation of Coverage

If an Insured Person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

1) First, the benefits of a plan covering the Insured Person as an Employee, member or subscriber (or as the Insured Person's Dependent);
2) Second, the benefits under the continuation coverage.

D. Longer/Shorter Length of Coverage

If none of the above rules determine the order of benefits, the benefits of the plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Insured Person for the shorter term.

Effect on the Benefits of This Plan:

This Section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this Section.

1. Reduction in this Plan's Benefits

The benefits of This Plan will be reduced when the sum of:

a) The benefits that would be payable for the Allowable Amount under this Plan in the absence of this COB provision; and

b) The benefits that would be payable for the Allowable Amount under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceed those Allowable amounts in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

The Company may, without consent from or notice to such Insured Person, release to or obtain from any organization or individual, information concerning an Insured Person which the Company determines to be necessary to implement these COB provisions. Any Insured Person claiming benefits from the Company must furnish the Company with any information necessary to implement such provisions.

If the Company provides benefits in excess of those would be required to provide under Coordination of Benefits, it shall have the right to recover the excess payment. The Insured Person is required to assist the Company in recovering any excess payment, including completing and filing claim forms with another insurance company or organization and endorsing claims payment checks over to the Company.

If benefits which should have been provided by the Company have been provided by another plan, the Company will have the right, exercisable alone and in its sole discretion, to reimburse such plan whatever amount the Company determines necessary to satisfy the intent of these provisions. The Company is discharged from liability under this Policy to the extent of any payment made under this provision.

2. 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. The Company need not tell, nor get the consent of any person to do this. Each person claiming benefits under **This Plan** must give any facts needed to pay the claim.

3. 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.

4. Right of Recovery

If the amount of 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.

Insured Person(s) are required to assist the Company to implement this section. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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.. 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. In the absence of fraud, all statements made by the Policyholder shall be deemed representations and not warranties and no such statement will be used in any contest under the Policy, unless a written instrument containing the statement is furnished to the Policyholder. 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 of Texas.

ADDENDUM TO CERTIFICATE

APPEAL PROCEDURE

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

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

DEFINITIONS

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

"Adverse benefit determination" is a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational.

"Adverse coverage determination" is an initial determination by the Company resulting in a denial, reduction, or failure to make payment (in whole or in part) of a claim due to lack of eligibility for coverage or policy limitations or exclusions.

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

"Relevant" means a document, record, or other information will be considered "**relevant**" to a given claim:

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

PROCEDURE

You or Your authorized representative may file an appeal with Us within 180 days of receipt of an adverse claim determination. To file an appeal, telephone the toll-free number listed in Your Certificate of Coverage or on Your ID card. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination. The Appeal decision will be made by a dentist advisor of the same or similar specialty as the provider of record.

For an appeal of an Adverse Coverage Determination, We will review the appeal and notify You of Our decision within 60 days of the request for appeal. If the determination is an Adverse Coverage Determination, We will send You and the provider of record a notice of the Adverse Coverage Determination will include the following in written or electronic form:

a) the specific reason for the decision;
b) reference to specific plan provisions on which the decision was based;
c) a statement that You are entitled to receive upon request and free of charge, reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts;
d) a statement of Your right to bring a civil action under ERISA; and

e) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Appeal of an Adverse Benefit Determination can be made orally or in writing. We will review the appeal and notify You and the provider of record of the decision within 30 days unless circumstances necessitate an extension in which case We may extend the determination period up to 15 days. An extension notification will be sent to You and the provider of record which will communicate the circumstances necessitating the extension and the date the determination is expected to be made. If further information is necessary to make the determination, We will specifically describe the information needed and the time period allowed for making the determination(s) will be pended for up to 45 days or until the information is received. Upon receipt of all information necessary to make the determination(s), We will send written notification of the appeal decision. Notice of the Adverse Benefit Determination will include the following in written or electronic form:

a) the appeal decision;
b) a statement of the specific dental or contractual reasons for the resolution;
c) the clinical basis for the decision;
d) the specialization of any dentist advisor consulted (if applicable);
e) notice of Your right to seek review of the denial by an independent review organization and the procedures for obtaining that review;
f) a statement of Your right to bring a civil action under ERISA; and
g) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Within ten (10) working days of the date of an Adverse Benefit Determination, the provider of record may request that another review be performed by a specialty provider who would typically manage the dental condition, procedure or treatment under review if good cause for such a review can be shown. We will complete the specialty review within 15 working days of the date the request is received.

You or the provider of record may seek review of an appeal decision of an Adverse benefit determination from an independent review organization. Within three (3) business days after the receipt of a request for independent review, We will provide the independent review organization the following:

a) a copy of any medical records possession that are relevant to the review;
b) a copy of any documents used by Us in making the determination(s) to be reviewed by the independent review organization;
c) a copy of the written notification of the appeal determination;
d) any documents and other written information submitted to Us in support of the appeal;
e) a listing of each Dentist known by Us who has either provided care to the enrollee or may have medical records relevant to the appeal.

We will comply with the independent review organization's determination.

TEXAS FEDERAL 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 and is replaced with the following:

Dependent(s) - Certificate Holder's enrolled spouse and any enrolled child, adoptive child or child party to a suit in which the Certificate Holder seeks to adopt the child, stepchild or unmarried grandchild of a Certificate Holder, regardless of the grandchild's dependent status for federal income tax purposes, or an enrolled child subject to a court order or as mandated by an administrative agency without regard to the child's place of residence:

(a) until the end of the month the child reaches the limiting age of 26; or
(b) to any age beyond the limiting age 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 or if the child is medically certified as disabled.

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 under another policy or contract or any combination of these factors.

The subsection entitled "Enrollment Changes" is deleted from the "ELIGIBILITY AND ENROLLMENT – WHEN COVERAGE BEGINS" section and is replaced by the following:

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 or initiation of a suit to adopt a child or stepchild;
- addition of a grandchild;
- court order or custody of a child or stepchild;
- marriage of the Certificate Holder or other life change event defined by Your Group.

To enroll a new Dependent as a result of one of these events, You must notify Your Group and supply the required enrollment change information within 31 days of the date You acquired the Dependent. If Your child is the subject of a medical support order, the child will be considered automatically enrolled for the first 31 days after the date We receive either the medical support order or a notice of medical support order. If You are required to provide coverage for a Dependent child pursuant to a court order, You, the child's custodial parent or a child support agency having a duty to collect or enforce support for the child will be permitted to enroll the Dependent child without regard to enrollment season restrictions. The Dependent must meet the requirements detailed in the definition of Dependent in the Definitions section of this Certificate.

Except for newly born child, adoptive child or grandchild, 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, placement, or the date on which the Member becomes a party to a suit in which the Member seeks to adopt the child, 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 children, adoptive children or grandchildren 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 31 days after said Dependent attains the limiting age shown in the definition of Dependent. Such evidence will be requested based on information provided by the Member's physician but no more frequently than annually.

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

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

No person can enroll as a Dependent if they are also enrolling as an Employee (such as a spouse). No person can be an eligible Dependent for more than one eligible Employee.

IT IS THE ENROLLED EMPLOYEE'S RESPONSIBILITY TO KEEP THE COMPANY ADVISED OF CHANGES THAT AFFECT EACH DEPENDENT'S STATUS.

The subsection entitled "Late Enrollment" is deleted from the "ELIGIBILITY AND ENROLLMENT – WHEN COVERAGE BEGINS" section and is replaced by the following:

Late Enrollment

If You or Your Dependents are not enrolled within 31 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 unless otherwise required by applicable state or federal law or permitted by Your Group under the rules of its benefit plans. 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.

The subsection entitled "Voluntary Disenrollment" has been deleted from the "ELIGIBILITY AND ENROLLMENT – WHEN COVERAGE BEGINS" section and is replaced by the following:

Voluntary Disenrollment

If You chose to drop Your coverage or Your Dependents' coverage under the Plan at any time during the contract year or during open enrollment, You will not be permitted to enroll Yourself or Your dependents at a later time unless You supply proof of loss of coverage under another dental plan or You or Your Dependents are eligible for a special enrollment period required by applicable state or federal law or permitted by Your Group under the rules of its benefits plans. The loss of coverage must be due to a valid life change event such as death, divorce or change in employment status of spouse. If You supply such proof, You will be permitted to re-enroll.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION (For insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas **(regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met:
    1. The policyholder has a policy with a company domiciled in Texas;
    2. The policyholder's state of residence has a similar guaranty association; and
    3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, or $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance
Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

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)

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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)

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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.

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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.

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