

UNITED CONCORDIA
America's Premier Dental Insurer

**UNITED CONCORDIA LIFE AND HEALTH
INSURANCE COMPANY**

**4401 Deer Path Road
Harrisburg, PA 17110**

**Dental Plan
Certificate of Insurance**

MD9804 (07/02)

CERTIFICATE OF INSURANCE

INTRODUCTION

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

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

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

(888) 638-3384

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

www.unitedconcordia.com

Claim forms should be sent to:

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

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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 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. A copy of the Certificate will be provided for each Certificate Holder.

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 payment to 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.

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, or grandson/granddaughter 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 incapacity and chiefly dependent upon the Certificate Holder for maintenance and support.

A child of a Certificate Holder will not be denied the status of Dependent on the grounds that the child: (a) was born out of wedlock; (b) is not claimed as a dependent on the Certificate Holder's federal income tax return; (c) does not reside with the Certificate Holder or the Company's service area; or (d) is receiving benefits or is eligible to receive benefits under the Maryland Medical Assistance Program.

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 grace period of 31 days will be granted for payment of each Premium due after the first Premium, unless We do not intend to renew the policy beyond the period for which Premium has been accepted. Notice of the intention not to renew will be delivered to the Policyholder at least 45 days prior to the due date of the Premium. During the grace period the Policy shall remain in force.

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.

Order – A ruling that is issued by a court of this State or another state or an administrative agency of another state; and creates or recognizes the right of a child to receive benefits under a parent's health coverage or establishes a parent's obligation to pay child support and provide health insurance coverage for a child.

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.

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 31 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 and grandchildren 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 incapacitated, 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, unless otherwise specified in any applicable Late Entrant Rider to the Certificate of Insurance.

Continuous open enrollment is available without evidence of insurability to: (a) Your spouse and children for 6 months after Your spouse loses coverage under another group plan due to involuntary termination of employment (not for cause); and (b) Your children for 6 months after a child loses coverage under Your spouse's group plan due to spouse's death. Eligible new employees, Members or Dependents may be added periodically to the Group Policy in accordance with its terms.

In addition, if a parent is subject to a court or administrative Order creating or recognizing a right of a child to receive benefits under the parent's health insurance coverage, then continuous open enrollment is available to: (a) You and Your Dependent child as to whom the Order applies; or (b) the non-insuring parent, the Child Support Enforcement Agency, or the Department of Health and Mental Hygiene for enrollment on behalf of the Dependent child.

We will provide to the non-insuring parent membership cards, claim forms, and any other information necessary to obtaining benefits for insurance coverage for the Dependent child. We will process claim forms and make appropriate payment to the non-insuring parent, dental provider or Department of Health and Mental Hygiene if the non-insuring parent incurs expenses for dental care for the Dependent child.

We will not disenroll or eliminate health insurance coverage for a Dependent child unless written evidence is provided to the Us that: (a) the Order is no longer in effect; (b) the child has been or will be enrolled under other reasonable health insurance coverage which will take effect not later than the effective date of the disenrollment; (c) Your Group has eliminated family health coverage; or (d) You are no longer enrolled with Your Group subject, however, to the rights of You an/or Your Dependent child under the Consolidated Omnibus Budget Reconciliation act of 1985 (COBRA).

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 make payment to 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. 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 payment 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.

Notice of Claim

Written notice of claim must be given to Company within twenty days after the occurrence or commencement of the loss covered by the certificate, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Member or the beneficiary, to the Company at the address as noted in the Introduction section of the Certificate or to any authorized agent of the Company, with information sufficient to identify the Member, shall be deemed notice to the Company.

Claims Forms

Company, upon receipt of a notice of claim, will furnish to the Member such forms as are usually furnished by Company for filing claims. If such forms are not furnished within fifteen days after the giving of such notice, the Member shall be deemed to have complied with the required time for filing a claim, upon submitting written proof of the occurrence and a written statement of the nature and extent for which the claim is being made.

Proofs 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 1 year from the time proof is otherwise required.

Time of Payment of Claims

All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid no later than 30 days from receipt of due written proof of such loss.

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 *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 curettage, osseous surgery, crown lengthening, bone and tissue replacement grafts
- Complex Oral Surgery for surgical treatment of the hard and soft tissues of the mouth – surgical extractions, impactions, excisions, exposure, root removal; alveoplasty and vestibuloplasty
- Anesthesia for elimination of pain during treatment – general or nitrous oxide or IV sedation
- Inlays, Onlays, Crowns when the teeth cannot be restored by fillings
- Prosthetics – fixed bridges, partial and complete dentures
- Orthodontics for treatment of poor alignment and occlusion – diagnostic x-rays, active treatment and retention for eligible dependent children

Exclusions and Limitations

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

Payment of Benefits

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

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

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

Overpayments

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

Coordination of Benefits (COB)

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

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

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

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

Workers' Compensation

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

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. This provision includes orthodontic treatment. 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, We will provide covered benefits, in accordance with the policy in effect at the time Your coverage terminates, for 60 days after the date coverage terminates if Your provider has agreed to or is receiving monthly payments, or until the later of 60 days after the date coverage terminates or the end of the quarter in progress if Your provider has agreed to accept or is receiving payments on a quarterly basis.

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. If We do not intend to renew the Policy beyond the period for which Premium has been accepted notice of the intention not to renew will be delivered to the group Policyholder at least 45 days before Premium is due.

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.

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 and may not be valid unless shown in an endorsement and signed by an executive officer of the Company.

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 Maryland.

Contestability of Coverage

There will be no contest of the validity of the Group Policy, except for not paying Premiums, after it has been in force two (2) years after the Effective date. No statement made by an insured Member relating to insurability may be used in contesting the validity of the Group Policy after the Member's coverage has been in force before the contest for a period of two (2) years. Absent fraud, all statements made by the Policyholder or by any insured Member shall be deemed representations and not warranties. No statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in writing and signed by the Policyholder and a copy of the statement is furnished to the person or to his beneficiary or personal representative or Group Policyholder.

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 written proof of loss has been furnished 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.

MARYLAND APPEAL and GRIEVANCE PROCEDURE 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. Members may call the Company's Member Services at (888) 638-3384, or write to the Company at UCCI Maryland Appeal, P.O. Box 69414, Harrisburg PA 17106-9414. 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 procedure have the meanings shown below.

"Adverse benefit determination" is a denial, reduction, or termination of or failure to make payment (in whole or in part) based on a determination of eligibility to participate in a plan; or a determination that an item or service otherwise covered is Experimental or Investigational; or a determination that an item or service is not covered by the Plan.

"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.

"Coverage Decisions" is the initial determination by the Company resulting in non-coverage of a dental care service. For utilization review determinations based on dental necessity or appropriateness, see the Grievance Procedure in this Addendum. A coverage decision is not an adverse decision.

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

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

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

Procedure

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

We will review the claim and notify You of Our decision within 30 days of the request for an appeal. Within 30 calendar days after a coverage decision has been made, the Company will send a written notice of the coverage decision to the Member and to the treating provider.

The notice of coverage decision from the Company shall include:

1. the specific factual basis for the Company's decision in detailed and clear, understandable language.
2. a statement that the Member, or health care provider acting on behalf of the Member, has a right to file an appeal with the Company. The Company's internal appeal process must be exhausted before a Member may file a complaint with the Commissioner of Insurance.
3. a statement that the Member or health care provider acting on behalf of the Member, may file a complaint with the Commissioner without first filing an appeal, if the coverage decision involves an urgent medical condition for which care has not been rendered. The Commissioner's address is as follows:

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

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

**Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1841 or toll-free: 877-261-8807
Fax: 410-576-6571
Email: heau@oag.state.md.us
Website: <http://www.oag.state.md.us>**

Appeals Procedure

You may request reconsideration of a coverage decision by submitting a written appeal to Us. We will re-consider the coverage decision. The appeal will be reviewed and a final decision rendered. The final decision will be in writing to the Member and the health care provider acting on behalf of the Member, within 60 working days after the date on which the appeal is filed.

The final decision will include a written notice of the appeal decision. Written notice of the appeal decision will be sent within 30 calendar days of the appeal decision to the Member and the health care provider acting on behalf of the Member. The notice of the appeal decision required to be sent shall include the following:

- a. the specific factual basis for the Company's decision in detailed and clear, understandable language.
- b. that the Member or health care provider acting on behalf of the Member, has a right to file a complaint with the Commissioner within 60 working days after receipt of the Company's appeal decision. The Commissioner's address is as follows:

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

GRIEVANCE PROCEDURE

If You are dissatisfied with Our adverse decision on a claim, You may appeal Our decision by following the steps outlined in this grievance procedure. We will resolve Your grievance in a thorough, appropriate, and timely manner to ensure that You are afforded a full and fair review of claims for benefits. Grievance 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 grievances. Members may call the Company's Dental Advisor Unit at (800-772-1133), or write to the Company at UCCI Maryland Grievance, Dental Advisor Unit, P.O. Box 69420 Harrisburg PA 17106-9420. We will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by Us required under these procedures will be supplied to You or Your authorized representative.

Definitions

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

"Adverse decision" means a utilization review determination based on dental necessity by the Company or appropriateness that results in a determination that the service is not covered by the Plan.

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

"Complaint" means a protest filed with the Commissioner involving an adverse decision or grievance decision concerning the Member.

"Dental Necessary" means a dental service or procedure is determined by a dentist to either establish or maintain a Member'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 health care provider and the Company on whether or not a dental service or procedure is dentally necessary, the opinion of the Company will be final. You or your health care provider may contact the Dental Advisor Unit at (800) 772-1133 if You have any questions regarding a dental necessity request.

"Filing Date" means the earlier of 5 days after the mailing or the date of receipt.

"Grievance" means a protest filed by the Member or health care provider on behalf of a Member with Us through Our grievance procedure regarding an adverse decision concerning the Member.

"Grievance Decision" means a final determination by the Company that arises from a grievance filed with the Company through our grievance procedure regarding an adverse decision concerning a Member.

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

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

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

Maryland Notification Procedure

We will send an adverse decision notice to You and Your health care provider within 5 working days after the adverse decision is made. The adverse decision notice shall include:

1. the specific factual basis for the Company's decision in detailed and clear, understandable language.
2. will contain references to the specific criteria on which the decision was based.
3. information on how to file a grievance with the Company.
4. a statement that You or a health care provider acting on behalf of the Member, may file a complaint with the Commissioner within 30 working days before a grievance is filed with the Company if the member can demonstrate a compelling reason to do so. The Commissioner's address is as follows:

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

5. a statement that the Health Advocacy Unit is available to assist You in filing grievance under Our internal grievance procedure. You may contact the Health Advocacy Unit at:

**Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1841 or toll-free: 877-261-8807
Fax: 410-576-6571
Email: heau@oag.state.md.us
Website: <http://www.oag.state.md.us>**

Maryland Grievance Procedure

You or Your authorized representative may file a grievance with Us no later than 180 days after the receipt of an adverse decision. To file a grievance, contact the Company at the addressed below:

**Dental Advisor Unit – Maryland Grievance
United Concordia Companies, Inc.
P.O. Box 69420
Harrisburg, PA 17106
Phone: 1-800-772-1133**

If We do not have sufficient information to review Your grievance, We will notify You or your health care provider within 5 working days that We can not proceed with the review of the grievance unless additional information is provided. We will assist you in gathering the necessary information to review the grievance.

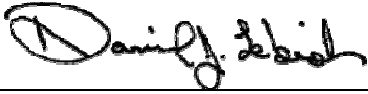
Within 45 working days after the filing date , the Company will render a final decision and will send a written notice of the grievance decision to the Member and to the treating provider. The notice of grievance decision from the Company will be sent within 5 working days of the adverse decision and shall include:

1. the specific factual basis for the Company's decision in detailed and clear, understandable language.
2. will contain references to the specific criteria on which the decision was based.
3. the name, address, and telephone number You may contact for the Company's grievance procedure.

4. a statement that the Member or health care provider acting on behalf of the Member, may file a complaint with the Commissioner within 30 working days after receipt of Our grievance decision. The Commissioner's address is as follows:

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

United Concordia Life and Health Insurance
Company



Authorized Officer

Customer Name

State of Maryland

Authorized Officer

UNITED CONCORDIA
ADDENDUM
TO
GROUP POLICY AND CERTIFICATE OF INSURANCE

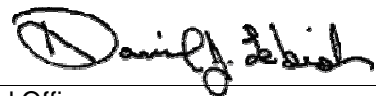
This Addendum is effective on the Effective Date as stated in the Group Policy and attached to and made part of the Group Policy and Certificate of Insurance.

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.

United Concordia Life and Health Insurance
Company



Authorized Officer

FEDERAL LAW SUPPLEMENT
TO
CERTIFICATE OF INSURANCE

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

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

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

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

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

United Concordia Life and Health Insurance Company

a wholly owned subsidiary of United Concordia Companies, Inc.
4401 Deer Path Road, Harrisburg, PA 17110

Concordia PPOsm

Group Name: State of Maryland PPO

Group Number: 842843000, 842843001,

Effective Date: July 1, 2009

842843002, 842843004, 842843006,

842843007, 842843008, 842843009

	<u>Plan Pays</u>
Class I Services	
• Exams	100%
• All X-Rays	100%
• Cleanings & Fluoride Treatments	100%
• Sealants	100%
• Palliative Treatment (Emergency)	100%
Class II Services	
• Space Maintainers	70%
• Basic Restorative (Fillings, etc.)	70%
• Endodontics	70%
• Non-surgical Periodontics	70%
• Repairs of Crowns, Inlays, Onlays	70%
• Repairs of Bridges	70%
• Denture Repair	70%
• Simple Extractions	70%
• Surgical Periodontics	70%
• Complex Oral Surgery	70%
• General Anesthesia	70%
Class III Services	
• Inlays, Onlays, Crowns	50%
• Prosthetics (Bridges, Dentures)	50%
Orthodontics	
• Diagnostic, Active, Retention Treatment	50%
• Limited to Dependent children under the age of 25	

Deductibles & Maximums

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

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

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

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – DPPO Plan

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

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

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

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

LIMITATIONS - DPPO

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

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

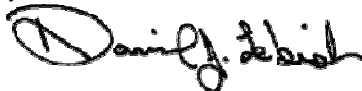
United Concordia
Rider to Schedule of Benefits
Preventive Incentive®

This Rider is effective on July 1, 2009 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, 2009 and is attached to and made a part of the Schedule of Benefits and Schedule of Exclusions and Limitations.

SCHEDULE OF BENEFITS

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

Implantology Services

Surgical Services

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

Supporting Structures

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

Implant/Abutment Supported Removable Dentures

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

Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)

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

Single Crowns, Abutment Supported

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

Single Crowns, Implant Supported

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

Fixed Partial Denture, Abutment Supported

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

MDR-Implant (03/07)

Fixed Partial Denture, Implant Supported

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

Other Repair Procedures

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

Deductible(s)

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

Maximum(s)

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

Waiting Period(s)

No Waiting Period will be applied to implantology services.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

The Schedule of Exclusions and Limitations is amended as follows:

Exclusions

Any exclusions relating to implantology services are deleted.

Limitations

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

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

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

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

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

UNITED CONCORDIA LIFE AND HEALTH
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Authorized Officer

MDR-Implant (03/07)

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