

**Discrimination is Against the Law**

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

**The Plan:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: [CivilRightsCoordinator@highmark.com](mailto:CivilRightsCoordinator@highmark.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-332-0366 (TTY: 711).
Español (Spanish)	ATENCIÓN: Si habla español, le ofrecemos servicios gratuitos de asistencia lingüística. Llame al 1-800-332-0366 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-0366 (TTY: 711)。
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-800-332-0366 (TTY: 711).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-0366 (TTY: 711) 번으로 전화해 주십시오.
Tagalog (Tagalog - Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-332-0366 (TTY: 711).
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните 1-800-332-0366 (телетайп: 711).
العربية (Arabic)	يرجى الانتباه: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة اللغوية المجانية. اتصل على 1-800-332-0366 (TTY: 711)
Kreyòl Ayisyen (French Creole)	ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis èd nan lang ki disponib gratis pou ou. Rele nimewo 1-800-332-0366 (TTY: 711).
Français (French)	ATTENTION : si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Appelez le 1-800-332-0366 (ATS: 711).
Polski (Polish)	UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-0366 (TTY: 711).
Português (Portuguese)	ATENÇÃO: se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-800-332-0366 (TTY: 711).
Italiano (Italian)	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-332-0366 (TTY: 711).
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Dienste für die sprachliche Unterstützung zur Verfügung. Rufnummer: 1-800-332-0366 (TTY: 711).
日本語 (Japanese)	注意事項：日本語をお使いの方は、言語面でのサポートを無償でご利用いただけます。1-800-332-0366（TTY: 711）まで、お電話にてご連絡ください。
فارسی (Farsi)	توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-332-0366 (TTY: 711) تماس بگیرید.

**United Concordia Dental Plans, Inc.**

*1800 Center Street, Suite 2B 220  
Camp Hill, PA 17011*

**Dental Plan**  
**Certificate of Coverage**  
ARCHDIOCESE OF BALTIMORE

## **CERTIFICATE OF COVERAGE**

### **INTRODUCTION**

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

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

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

866-357-3304

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

[www.unitedconcordia.com](http://www.unitedconcordia.com)

Claim forms should be sent to:

United Concordia Companies, Inc.  
Dental Claims  
PO Box 69422  
Harrisburg, PA 17106-9422

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### ATTACHED:

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

**Annual Maximum(s)** - The greatest amount the Company is obligated to pay for all Covered Services rendered during a calendar year or Contract Year as shown on the Schedule of Benefits.

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

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

**Company** – United Concordia Dental Plans, Inc.

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

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

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

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

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

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

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

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

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

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

1. The Certificate Holder's Spouse, or domestic life partner as defined by the Contractholder and/or state law; and
2. Any unmarried natural child, stepchild, grandchild, adopted child or child placed with the Certificate Holder or the Certificate Holder's Spouse or domestic partner:
  - (a) until the end of the month that the child reaches age twenty-six (26); or

- (b) until the end of the month which he/she reaches age twenty-six (26) if he/she is a full-time student at an accredited educational institution and is chiefly reliant upon the Certificate Holder for maintenance and support; or
  - (c) to any age if the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical incapacity and chiefly dependent upon the Certificate Holder for support
3. Any unmarried natural child, stepchild, grandchild, adopted child or child placed for adoption with the Certificate Holder or the Certificate Holder's Spouse or domestic partner by order of a court or administrative agency, subject to 2 a-c above. In this case:
- (a) the insuring parent shall be allowed to enroll in a family members' coverage and include the child in that coverage regardless of enrollment period restrictions;
  - (b) if the insuring parent is enrolled in health insurance coverage but does not include the child in the enrollment, then:
    - (i) The non-insuring parent, child support enforcement agency, or Department of Health and Mental Hygiene may apply for enrollment on behalf of the child; and
    - (ii) include the child in the coverage regardless of enrollment period restrictions; and
  - (c) We will not terminate health insurance coverage for the child unless written evidence is provided to the entity that:
    - (i) the order is no longer in effect;
    - (ii) the child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;
    - (iii) the employer has eliminated family members' coverage for all of its employees; or
    - (iv) the employer no longer employs the insuring parent, except that if the parent elects to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage shall be provided for the child consistent with the employer's plan for postemployment health insurance coverage for dependents.
4. Any unmarried natural child, stepchild, grandchild, by order of a court or administrative agency subject to 2 a-c above, who is under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration, of the insured, subscriber, employee, or member.

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

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

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

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

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

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

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

**Lifetime Maximum(s)** - The greatest amount the Company is obligated to pay for all Covered Services rendered during the entire time the Member is enrolled under the Group Contract, as shown on the Schedule of Benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

**Service Area** – The state of Maryland.

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



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

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

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

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

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

## **ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS**

### **New Enrollment**

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

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

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

Coverage for Members enrolling after the Group Contract Effective Date will begin on the date specified in the enrollment information supplied to Us provided Premium is paid.

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

### **Special Enrollment Periods - Enrollment Changes**

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

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

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

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

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

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

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

For an enrolled Dependent child who is mentally or physically incapacitated, proof of his/her reliance on You for support due to his/her condition must be supplied to Us within thirty (30) days after said Dependent attains the limiting age shown in the definition of Dependent. The Company will send notification to the Member at least ninety (90) days prior to the date the dependent child attains the limiting age. Such evidence will be requested based on information provided by the Member's physician but no more frequently than annually.

Dependent coverage may only be terminated when certain life change events occur including death, divorce or dissolution of the union or domestic partnership, reaching the limiting age or during open enrollment periods, or specified in any applicable Late Entrant Rider to the Certificate of Coverage.

### **Late Enrollment**

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

## **HOW THE DENTAL PLAN WORKS**

### **Choice of Provider at Enrollment**

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

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

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

### **Changing Primary Dental Offices**

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

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

### **Continuity of Care**

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

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

### **Coordination of Care and Referrals**

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

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

### **Standing Referral Guidelines**

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

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

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

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

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

#### Out-of-Network Referral Guidelines

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

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

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

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

Should You have any questions concerning Your coverage, eligibility or a specific claim, contact Us at the address and telephone number in the Introduction section of this Certificate or log onto Our website.

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

#### Dental Emergencies

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

#### Out-of-Network Care

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

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

## **BENEFITS**

### **Covered Services**

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

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

### **Exclusions**

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

### **Copayments and Other Charges**

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

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

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

### **Other Charges for Alternate Treatment**

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

## **Payment of Benefits**

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

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

If, during the term of this Contract, none of the In-Network Dentists can render necessary care and treatment to You due to circumstances not reasonably within Our control, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, or the disability of a significant number of the In-Network Dentists, then You may seek treatment from a licensed Out-of-Network Dentist of Your choice. We will pay You for the expenses incurred for the dental services with the following limitations: We will pay You for the services which are listed in the Copayment schedule as No Charge, to the extent that such fees are reasonable and customary for Dentists in the same geographic area; We will also pay You for those services listed in the Contract for which there is a Copayment, to the extent that the reasonable and customary fees for such services exceed the Copayment for such services as set forth in the Contract. You may be required to give written proof of loss (file a claim). The Company agrees to be subject to the jurisdiction of the Maryland Insurance Commissioner in any dispute about the possibility of providing services by In-Network Dentists.

## **Coordination of Benefits (COB)**

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

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

- F) **Plan** means this document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.
2. The fair value of services provided by the Company will be considered to be the amount of benefits paid by the Company. The Company will be fully discharged from liability to the extent of such payment under this provision.
3. In order to determine which plan is primary, this Plan will use the following rules.
- A) If the other plan does not have a provision similar to this one, then that plan will be primary.
- B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent; however if the Covered Person is a Medicare Beneficiary, then Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent.
- C) Dependent Child/Parents Who are Married or are Living Together -- The rules for the order of benefits for a Dependent child when the parents are married or are living together are:
- 1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
  - 2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
  - 3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
  - 4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
- D) Dependent Child/Separated or Divorced Parents or Parents Who Are no Longer Living Together -- If two or more plans cover a person as Dependent child of divorced or separated parents, or parents who are no longer living together, benefits for the child are determined in this order:
- 1) First, the plan of the parent with custody of the child.
  - 2) Second, the plan of the spouse of the parent with the custody of the child; and
  - 3) Third, the plan of the parent not having custody of the child.
  - 4) Finally the plan of the spouse of the parent not having custody of the child.
  - 5) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
  - 6) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 3-C) above, titled Dependent Child/Parents Not Separated or Divorced.
- E) Active/Inactive Member
- 1) The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
  - 2) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
  - 3) This rule does not apply if the rule in Paragraph (3.B) can determine the order of benefits.
- F) The plan covering an individual as a COBRA or state continuee will be secondary to a plan covering that individual as a Member or a Dependent.
- G) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary and the plan that covered the person for the shorter period of time is secondary. In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when

combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

- H) 1. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.
2. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.
3. The start of a new plan does not include: A change in the amount or scope of a plan's benefits; A change in the entity that pays, provides or administers the plan's benefits; or A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.
4. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.
4. Right to Receive and Release Needed Information -- Certain facts are needed to apply these COB rules. The Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Any health information furnished to a third party will be released in accordance with state and federal law. Each person claiming benefits under This Plan must give any facts needed to pay the claim.
5. Facility of Payment -- A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Company may pay the amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan, and the Company will not pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the services prepaid by the Company.
6. Right of Recovery -- If the payment made by the Company is more than it should have paid under this COB provision, the Company may recover the excess from one or more of the following: (1) persons it has paid or for whom it has paid; or (2) insurance companies; or (3) other organization. Members are required to assist the Company to implement this section.

### **Workers' Compensation**

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

### **Review of a Benefit Determination**

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

## **TERMINATION -- WHEN COVERAGE ENDS**

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



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

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

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

We are not liable to pay any benefits for services that are started after Your Termination Date or after the Group Contract Termination Date. However, coverage for completion of a dental procedure requiring two (2) or more visits on separate days will be extended for a period of ninety (90) days after the Termination Date in order for the procedure to be finished. The procedure must be started prior to the Termination Date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. This extension does not apply if the Group Contract terminates for failure to pay Premium.

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

### **CONTINUATION COVERAGE**

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

### **CONVERSION OF COVERAGE**

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

Coverage under the Conversion Certificate of Coverage becomes effective on Your Termination Date for this Group Contract.

## **GENERAL PROVISIONS**

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

This Certificate will be construed for all purposes as a legal document and will be interpreted and enforced in accordance with pertinent laws and regulations of the State of Maryland.

### **Privacy and Confidentiality of Dental Records**

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

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

### **Rights of Company to Change Plan**

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

## **Continuity of Care Addendum to the Dental Plan Certificate of Coverage**

### **United Concordia Dental Plans, Inc.**

This Addendum is effective on the Effective date of the Policy. It is attached to and made part of the Dental Plan Certificate of Coverage (hereinafter "Certificate").

The following definition is added to the "DEFINITIONS" section of the Certificate:

**"Exception Cases"** are defined as:

- 1) situations where care is needed as a result of a Dental Emergency. See the provisions of this Rider on Dental Emergency.
- 2) when You have been receiving services from a dentist under prior coverage who is not an In-Network Dentist under this Plan. This right applies if You are being treated by the Out-of-Network Dentist for Covered Services for one or more of the following types of conditions:
  - a) an acute dental condition
  - b) a serious chronic dental conditions
  - c) any other condition upon which We and the Out-of-Network Dentist agree.

Under the above-listed conditions, You, Your parent, guardian, designee, Authorized Representative, or Dentist must contact Us within ninety (90) days from the Effective date of this plan on Your behalf to request the right to continue to see the Out-of-Network Dentist in order for these rights to be enacted. Doing so will allow you to continue to receive Covered Service from the Out-of-Network Dentist at the same Copayment levels as In-Network Dentists. The time limit is 90 (ninety) days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date your coverage starts under the new Dental Plan.

The following language is added to the "Coordination of Care and Referrals" section of the Certificate is amended as follows:

### **Coordination of Care and Referrals**

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

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

### **Standing Referral Guidelines**

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

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

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

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

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

#### Out-of-Network Referral Guidelines

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

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

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

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

Should You have any questions concerning Your coverage, eligibility, Exception Case eligibility or a specific claim, contact Us at the address and telephone number in the Introduction section of this Certificate or log onto Our website.

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

The following language is added to the "Out-of-Network" section of the Certificate:

#### **Out-of-Network Care**

You may also receive Covered Services from an Out-of-Network Provider under the Exception Cases.

The following language is added to the "General Provisions" section of the Certificate:

#### **Appeal Rights for Exception Cases**

- If we deny your appeal, you may file a complaint with the Maryland Insurance Administration. To receive a complaint form from the Maryland Insurance Administration call 1-800-492-6116, select option 3, then option 2 or download a complaint form from the Maryland Insurance Administration's website at [www.mdinsurance.state.md.us](http://www.mdinsurance.state.md.us).
- If you have any questions about this appeal or Exception Cases, please contact us at **1-866-357-3304**.

## **APPEAL PROCEDURE**

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

The following contains important information about how to file an Appeal. If You are dissatisfied with Our benefit determination on a claim, You may Appeal Our decision by following the steps outlined in this procedure. We will resolve Your Appeal in a thorough, appropriate, and timely manner. You, Your Authorized Representative, or Your Health Care Provider may submit written comments, documents, records and other information relating to claims or Appeals. You may call Us at , or write to Us at 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, Your Authorized Representative, or Your Health Care Provider.

### **Definitions**

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

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

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

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

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

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

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

"Coverage Decisions" is:

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

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

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

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

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

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

## **PROCEDURE FOR PRE-SERVICE CLAIM**

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

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

- a) The specific factual basis for Our decision in detailed and clear understandable language;
- b) A reference to specific plan provisions on which the decision was based;
- c) A statement that You, Your Health Care Provider, or Your Authorized Representative is entitled reasonable access to and copies of all relevant documents, records, and criteria. This includes an explanation of clinical judgment on which the decision was based and identification of the dental experts. All such information is available upon request and is free of charge.
- d) A statement of Your, Your Health Care Provider's or Your Authorized Representative's right to bring a civil action under ERISA; and
- e) A statement that the You, Your Health Care Provider, or Your Authorized Representative has a right to file an Appeal with Us. Our internal appeal process must be exhausted before You may file a Complaint with the Commissioner of Insurance.
- f) a statement that You, Your Health Care Provider, or Your Authorized Representative may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves an urgent medical condition for which care has not been rendered. The Commissioner's address is as follows:

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

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

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

## **Procedure for Post-Service Claim**

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

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

The notice of Coverage Decision from Us shall include:

1. the specific factual basis for Our decision in detailed and clear, understandable language.

2. a statement that the You, Your Health Care Provider, or Your Authorized Representative has a right to file an Appeal with Us. Our internal appeal process must be exhausted before You may file a Complaint with the Commissioner of Insurance.
3. a statement that You, Your Health Care Provider, or Your Authorized Representative may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves an urgent medical condition for which care has not been rendered. The Commissioner's address is as follows:

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

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

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

### **Appeals Procedure**

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

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

- a. the specific factual basis for Our decision in detailed and clear, understandable language.
- b. that You, Your Health Care Provider, or Your Authorized Representative has a right to file a Complaint with the Commissioner within four (4) months after receipt of Our Appeal decision, including the contact information as indicated above.
- c. a statement that You, Your Health Care Provider, or Your Authorized Representative may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves an urgent medical condition for which care has not been rendered. The Commissioner's address is as follows:

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

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

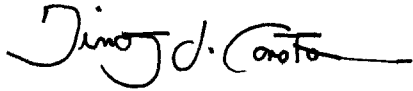
**Health Education and Advocacy Unit  
Consumer Protection Division  
Office of the Attorney General  
200 St. Paul Place, 16<sup>th</sup> Floor**

Baltimore, MD 21202  
Phone: 410-528-1840 or toll-free: 877-261-8807  
Fax: 410-576-6571  
Email: [heau@oag.state.md.us](mailto:heau@oag.state.md.us)  
Website: <http://www.oag.state.md.us>

**Issues other than Coverage Decisions**

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

United Concordia Dental Plans, Inc.

A handwritten signature in black ink, appearing to read "James J. Conato", written over a horizontal line.

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.

**IMPORTANT INFORMATION ABOUT YOUR PLAN**

- ▶ This schedule of benefits provides a listing of procedures covered by your plan. For procedures that require a copayment, the amount to be paid is shown in the column titled "Member Pays \$." You pay these copayments to the dental office at the time of service.
- ▶ You must select a United Concordia Primary Dental Office (PDO) to receive covered services. Your PDO will perform the below procedures or refer you to a specialty care dentist for further care. Treatment by an Out-of-Network dentist is not covered, except as described in the Certificate of Coverage.
- ▶ Only procedures listed on this Schedule of Benefits are Covered Services. For services not listed (not covered), You are responsible for the full fee charged by the dentist. Procedure codes and member Copayments may be updated to meet American Dental Association (ADA) Current Dental Terminology (CDT) in accordance with national standards.
- ▶ For a complete description of your plan, please refer to the Certificate of Coverage and the Schedule of Exclusions and Limitations in addition to this Schedule of Benefits.
- ▶ If you have any questions about your United Concordia dental plan, please call our Customer Service Department toll-free at 1-866-357-3304 or access our website at [www.UnitedConcordia.com](http://www.UnitedConcordia.com).

ADA Code	ADA Description	Member Pays \$	ADA Code	ADA Description	Member Pays \$
<b>CLINICAL ORAL EVALUATIONS</b>			<b>TESTS AND EXAMINATIONS</b>		
D0120	Periodic Oral Evaluation - Established Patient	5	D0460	Pulp Vitality Tests	0
D0140	Limited Oral Evaluation - Problem Focused	5	D0470	Diagnostic Casts	0
D0145	Oral Evaluation For A Patient Under 3 Years Of Age And Counseling With Primary Caregiver	5	<b>ORAL PATHOLOGY LABORATORY</b>		
D0150	Comprehensive Oral Evaluation - New Or Established Patient	5	D0601	Caries Risk Assessment And Documentation, With A Finding Of Low Risk	0
D0170	Re-Evaluation-Limited, Problem Focused (Established Patient; Not Post-Operative Visit)	5	D0602	Caries Risk Assessment And Documentation, With A Finding Of Moderate Risk	0
D0171	Re-Evaluation - Post-Operative Office Visit	0	D0603	Caries Risk Assessment And Documentation, With A Finding Of High Risk	0
D0180	Comprehensive Periodontal Evaluation	5	<b>DENTAL PROPHYLAXIS</b>		
<b>RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)</b>			D1110	Prophylaxis, Adult	0
D0210	Intraoral - Complete Series Of Radiographic Images	0	D1120	Prophylaxis, Child	0
D0220	Intraoral- Periapical First Radiographic Image	0	<b>TOPICAL FLUORIDE TREATMENT (office procedure)</b>		
D0230	Intraoral- Periapical Each Additional Radiographic Image	0	D1206	Topical Application Of Fluoride Varnish	0
D0240	Intraoral - Occlusal Radiographic Image	0	D1208	Topical Application Of Flouride - Excluding Varnish	0
D0270	Bitewing - Single Radiographic Image	0	<b>OTHER PREVENTIVE SERVICES</b>		
D0272	Bitewings - Two Radiographic Images	0	D1330	Oral Hygiene Instruction	0
D0273	Bitewings - Three Radiographic Images	0	D1351	Sealant - Per Tooth	0
D0274	Bitewings - Four Radiographic Images	0	D1353	Sealant Repair - Per Tooth	0
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	0	D1354	Application of Caries Arresting Medicament - Per Tooth	15
D0330	Panoramic Radiographic Image	0	D1355	Caries preventive medicament application - per tooth	15
D0340	2D Cephalometric Radiographic Image - Acquisition, Measurement And Analysis	0	<b>SPACE MAINTENANCE (passive appliances)</b>		
<b>TESTS AND EXAMINATIONS</b>			D1510	Space maintainer - fixed, unilateral - per quadrant	35
			D1516	Space Maintainer - Fixed - bilateral, maxillary	54

ADA Code	ADA Description	Member Pays \$		ADA Code	ADA Description	Member Pays \$	
SPACE MAINTENANCE (passive appliances)				CROWNS - SINGLE RESTORATIONS ONLY			
D1517	Space Maintainer - Fixed - bilateral, mandibular	54		D2712	Crown - 3/4 Resin-Based Composite (Indirect)	80	
D1520	Space maintainer - removable, unilateral - per quadrant	43		D2740	Crown, Porcelain/Ceramic	400	
D1526	Space Maintainer - Removable - bilateral, maxillary	86		D2750	Crown, Porcelain Fused To High Noble Metal	350	◆
D1527	Space Maintainer - Removable - bilateral, mandibular	86		D2751	Crown-Porcelain Fused To Predominantly Base Metal	320	
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	6		D2752	Crown, Porcelain Fused To Noble Metal	330	◆
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	6		D2753	Crown - porcelain fused to titanium and titanium alloys	330	
D1553	Re-cement or re-bond bilateral space maintainer - per quadrant	6		D2790	Crown, Full Cast High Noble Metal	350	◆
D1556	Removal of fixed unilateral space maintainer - per quadrant	26		D2791	Crown - Full Cast Predominantly Base Metal	320	
D1557	Removal of fixed unilateral space maintainer - maxillary	26		D2792	Crown, Full Cast Noble Metal	330	◆
D1558	Removal of fixed unilateral space maintainer - mandibular	26		D2794	Crown - titanium and titanium alloys	320	
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	35		D2799	Interim Crown - Further Treatment Or Completion Of Diagnosis Necessary Prior To Final Impression	66	
AMALGAM RESTORATIONS (including polishing)				OTHER RESTORATIVE SERVICES			
D2140	Amalgam - One Surface, Primary Or Permanent	0		D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	12	
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0		D2915	Re-Cement Or Rebond Indirectly Fabricated Or Prefabricated Post And Core	13	
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0		D2920	Re-Cement Or Re-Bond Crown	13	
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0		D2930	Prefabricated Stainless Steel Crown - Primary Tooth	52	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT				D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	60	
D2330	Resin-Based Composite - One Surface, Anterior	0		D2949	Restorative Foundation For An Indirect Restoration	0	
D2331	Resin-Based Composite - Two Surfaces, Anterior	0		D2950	Core Buildup Including Any Pins When Required	58	
D2332	Resin-Based Composite - Three Surfaces, Anterior	0		D2951	Pin Retention - Per Tooth, In Addition To Restoration	10	
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle (Anterior)	0		D2952	Post And Core In Addition To Crown, Indirectly Fabricated	81	
D2391	Resin-Based Composite - One Surface, Posterior	40		D2953	Each Additional Indirectly Fabricated Post - Same Tooth	41	
D2392	Resin-Based Composite - Two Surfaces, Posterior	65		D2954	Prefabricated Post And Core In Addition To Crown	79	
D2393	Resin-Based Composite - Three Surfaces, Posterior	80		D2957	Each Additional Prefabricated Post - Same Tooth	40	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	85		D2971	Additional Procedures To Customize a Crown to fit Under an Existing Partial Denture Framework	25	
INLAY/ONLAY RESTORATIONS				PULP CAPPING			
D2510	Inlay - Metallic - One Surface	186	◆	D3110	Pulp Cap - Direct (Excluding Final Restoration)	0	
D2520	Inlay - Metallic - Two Surfaces	207	◆	D3120	Pulp Cap - Indirect (Excluding Final Restoration)	0	
D2530	Inlay - Metallic - Three Or More Surfaces	256	◆	PULPOTOMY			
D2542	Onlay - Metallic-Two Surfaces	235	◆	D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	35	
D2543	Onlay - Metallic - Three Surfaces	275	◆	D3221	Pulpal Debridement, Primary And Permanent Teeth	26	
D2544	Onlay - Metallic - Four Or More Surfaces	302	◆	D3222	Partial Pulpotomy For Apexogenesis-Permanent Tooth With Incomplete Root Development	35	
CROWNS - SINGLE RESTORATIONS ONLY				ENDODONTIC THERAPY ON PRIMARY TEETH			
D2710	Crown-Resin-Based Composite (Indirect)	80					

ADA Code	ADA Description	Member Pays \$	ADA Code	ADA Description	Member Pays \$
<b>ENDODONTIC THERAPY ON PRIMARY TEETH</b>			<b>SURGICAL SERVICES (including usual postoperative care)</b>		
D3230	Pulpal Therapy (Resorbable Filling)- Anterior, Primary Tooth (Excluding Final Restoration)	60	D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	162
D3240	Pulpal Therapy (Resorbable Filling)- Posterior, Primary Tooth (Excluding Final Restoration)	72	D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	65
<b>ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)</b>			D4249	Clinical Crown Lengthening-Hard Tissue	216
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	165	D4260	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	260
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	200	D4261	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	104
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)	273	D4263	Bone Replacement Graft - Retained Natural Tooth - First Site In Quadrant	86
<b>ENDODONTIC RETREATMENT</b>			D4264	Bone Replacement Graft - Retained Natural Tooth - Each Additional Site In Quadrant	82
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	200	D4274	Mesial/Distal Wedge Procedure, Single Tooth (When Not Performed In Conjunction With Surgical Procedures In The Same Anatomical Area)	156
D3347	Retreatment Or Previous Root Canal Therapy - Premolar	241	<b>NON-SURGICAL PERIODONTAL SERVICES</b>		
D3348	Retreatment Of Previous Root Canal Therapy - Molar	313	D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	65
<b>APICOECTOMY/PERIRADICULAR SERVICES</b>			D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	16
D3410	Apicoectomy - Anterior	147	D4346	Scaling In Presence Of Generalized Moderate Or Severe Gingival Inflammation - Full Mouth, After Oral Evaluation	40
D3421	Apicoectomy - Premolar (First Root)	144	D4355	Full Mouth Debridement To Enable a Comprehensive Oral Evaluation And Diagnosis on a Subsequent Visit	35
D3425	Apicoectomy - Molar (First Root)	144	D4381	Localized Delivery Of Antimicrobial Agents Via Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth	100
D3426	Apicoectomy (Each Additional Root)	65	<b>OTHER PERIODONTAL SERVICES</b>		
D3430	Retrograde Filling - Per Root	0	D4910	Periodontal Maintenance	40
D3450	Root Amputation - Per Root	81	D4921	Gingival Irrigation - Per Quadrant	25
D3471	Surgical repair of root resorption – anterior	144	<b>COMPLETE DENTURES (including routine post delivery care)</b>		
D3472	Surgical repair of root resorption – premolar	144	D5110	Complete Denture - Maxillary	325
D3473	Surgical repair of root resorption – molar	144	D5120	Complete Denture - Mandibular	325
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	144	D5130	Immediate Denture - Maxillary	350
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	144	D5140	Immediate Denture - Mandibular	350
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	144	<b>PARTIAL DENTURES (including routine post-delivery care)</b>		
<b>OTHER ENDODONTIC PROCEDURES</b>			D5211	Maxillary Partial Denture - Resin Base (Including Retentive/Clasping Materials, Rests And Teeth)	245
D3920	Hemisection (Including Any Root Removal) Not Including Root Canal Therapy	76	D5212	Mandibular Partial Denture - Resin Base (Including Retentive/Clasping Materials, Rests And Teeth)	245
D3921	Decoronation or submergence of an erupted tooth	52			
D3950	Canal Preparation And Fitting Of Preformed Dowel Or Post	0			
<b>SURGICAL SERVICES (including usual postoperative care)</b>					
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	173			
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	54			
D4212	Gingivectomy Or Gingivoplasty To Allow Access For Restorative Procedure, Per Tooth	0			

ADA Code	ADA Description	Member Pays \$	ADA Code	ADA Description	Member Pays \$
PARTIAL DENTURES (including routine post-delivery care)			REPAIRS TO PARTIAL DENTURES		
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	350	D5611	Repair Resin Partial Denture Base, Mandibular	50
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	350	D5612	Repair Resin Partial Denture Base, Maxillary	50
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	245	D5621	Repair Cast Partial Framework, Mandibular	65
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	245	D5622	Repair Cast Partial Framework, Maxillary	65
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	350	D5630	Repair Or Replace Broken Retentive Clasping Materials - Per Tooth	65
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	350	D5640	Replace Broken Teeth-Per Tooth	50
D5225	Maxillary Partial Denture - Flexible Base (Including Retentive/Clasping materials, Rests And Teeth)	403	D5650	Add Tooth To Existing Partial Denture	60
D5226	Mandibular Partial Denture - Flexible Base (Including Retentive/Clasping materials, Rests And Teeth)	403	D5660	Add Clasp To Existing Partial Denture - Per Tooth	60
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	245	D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)	228
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	245	D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	228
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary	145	DENTURE REBASE PROCEDURES		
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular	145	D5710	Rebase Complete Maxillary Denture	130
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests and teeth) - per quadrant	145	D5711	Rebase Complete Mandibular Denture	130
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests and teeth) - per quadrant	145	D5720	Rebase Maxillary Partial Denture	115
ADJUSTMENTS TO DENTURES			D5721	Rebase Mandibular Partial Denture	115
D5410	Adjust Complete Denture - Maxillary	16	D5725	Rebase hybrid prosthesis	115
D5411	Adjust Complete Denture - Mandibular	16	DENTURE RELINE PROCEDURES		
D5421	Adjust Partial Denture - Maxillary	16	D5730	Reline Complete Maxillary Denture (direct)	60
D5422	Adjust Partial Denture - Mandibular	16	D5731	Reline Complete Mandibular Denture (direct)	60
REPAIRS TO COMPLETE DENTURES			D5740	Reline Maxillary Partial Denture (direct)	60
D5511	Repair Broken Complete Denture Base, Mandibular	50	D5741	Reline Mandibular Partial Denture (direct)	60
D5512	Repair Broken Complete Denture Base, Maxillary	50	D5750	Reline Complete Maxillary Denture (indirect)	85
D5520	Replace Missing Or Broken Teeth-Complete Denture (Each Tooth)	45	D5751	Reline Complete Mandibular Denture (indirect)	85
			D5760	Reline Maxillary Partial Denture (indirect)	85
			D5761	Reline Mandibular Partial Denture (indirect)	85
			D5765	Soft liner for complete or partial removable denture – indirect	60
			OTHER REMOVABLE PROSTHETIC SERVICES		
			D5850	Tissue Conditioning, Maxillary	40
			D5851	Tissue Conditioning, Mandibular	40
			D5863	Overdenture - Complete Maxillary	325
			D5864	Overdenture - Partial Maxillary	350
			D5865	Overdenture - Complete Mandibular	325
			D5866	Overdenture - Partial Mandibular	350
			FIXED PARTIAL DENTURE PONTICS		
			D6205	Pontic - Indirect Resin Based Composite	400
			D6210	Pontic-Cast High Noble Metal	350 ◆
			D6211	Pontic-Cast Predominantly Base Metal	320
			D6212	Pontic-Cast Noble Metal	330 ◆
			D6214	Pontic - titanium and titanium alloys	320
			D6240	Pontic-Porcelain Fused To High Noble Metal	350 ◆



ADA Code	ADA Description	Member Pays \$		ADA Code	ADA Description	Member Pays \$
<b>FIXED PARTIAL DENTURE PONTICS</b>				<b>ALVEOLOPLASTY (surgical preparation of ridge for dentures)</b>		
D6241	Pontic-Porcelain Fused To Predominantly Base Metal	320		D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	49
D6242	Pontic-Porcelain Fused To Noble Metal	330	◆	D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	60
D6243	Pontic - porcelain fused to titanium and titanium alloys	330		D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth Or Tooth Spaces, Per Quadrant	24
D6245	Pontic - Procelain/Ceramic	400		<b>SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS</b>		
<b>FIXED PARTIAL DENTURE RETAINERS - CROWNS</b>				D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	76
D6710	Retainer Crown - Indirect Resin Based Composite	400		<b>OTHER REPAIR PROCEDURES</b>		
D6740	Retainer Crown - Porcelain/Ceramic	400		D7961	Buccal / labial frenectomy (frenulectomy)	100
D6750	Retainer Crown, Porcelain Fused To High Noble Metal	350	◆	D7962	Lingual frenectomy (frenulectomy)	100
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	320		D7963	Frenuloplasty	50
D6752	Retainer Crown, Porcelain Fused To Noble Metal	330	◆	<b>LIMITED ORTHODONTIC TREATMENT</b>		
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	330		D8010	Limited Orthodontic Treatment Of Primary Dentition	750
D6790	Retainer Crown, Full Cast High Noble Metal	350	◆	D8020	Limited Orthodontic Treatment Of Transitional Dentition	750
D6791	Retainer Crown, Full Cast Predominantly Base Metal	320		D8030	Limited Orthodontic Treatment Of Adolescent Dentition	750
D6792	Retainer Crown, Full Cast Noble Metal	330	◆	D8040	Limited Orthodontic Treatment Of The Adult Dentition	750
D6794	Retainer crown - titanium and titanium alloys	320		<b>COMPREHENSIVE ORTHODONTIC TREATMENT</b>		
<b>OTHER FIXED PARTIAL DENTURE SERVICES</b>				D8070	Comprehensive Orthodontic Treatment Of Transitional Dentition	2900
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	31		D8080	Comprehensive Orthodontic Treatment Of Adolescent Dentition	2900
<b>EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)</b>				D8090	Comprehensive Orthodontic Treatment Of Adult Dentition	2900
D7111	Extraction, Coronal Remnants - Primary Tooth	11		<b>MINOR TREATMENT TO CONTROL HARMFUL HABITS</b>		
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	28		D8210	Removable Appliance Therapy For Control Of Harmful Habits	375
<b>SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)</b>				D8220	Fixed Appliance Therapy For Control Of Harmful Habits	375
D7210	Extraction, Erupted Tooth Requiring Removal Of Bone And/Or Sectioning Of Tooth, And Including Elevation Of Mucoperiosteal Flap If Indicated	52		<b>OTHER ORTHODONTIC SERVICES</b>		
D7220	Removal Of Impacted Tooth - Soft Tissue	64		D8680	Orthodontic Retention (Removal Of Appliances, Construction And Placement Of Retainer(S)	275
D7230	Removal Of Impacted Tooth - Partially Bony	86		†	Orthodontic Records Fee	250
D7240	Removal Of Impacted Tooth - Completely Bony	106		<b>UNCLASSIFIED TREATMENT</b>		
D7241	Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	121		D9110	Palliative (Emergency) Treatment Of Dental Pain, Minor Procedures	26
D7250	Removal Of Residual Tooth Roots (Cutting Procedure)	50		<b>PROFESSIONAL CONSULTATION</b>		
D7251	Coronectomy-Intentional Partial Tooth Removal	106		D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician Other Than Requesting Dentist Or Physician	28
<b>OTHER SURGICAL PROCEDURES</b>				D9311	Consultation With A Medical Health Care Professional	0
D7280	Exposure Of An Unerupted Tooth	102		<b>PROFESSIONAL VISITS</b>		
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	25		D9430	Office Visit For Observation (During Regularly Scheduled Hours) - No Other Services Performed	0
D7288	Brush Biopsy - Transepithelial Sample Collection	45		D9440	Office Visit After Regularly Scheduled Hours	54
<b>ALVEOLOPLASTY (surgical preparation of ridge for dentures)</b>						

ADA Code	ADA Description	Member Pays \$
<b>MISCELLANEOUS SERVICES</b>		
D9932	Cleaning And Inspection Of Removable Complete Denture, Maxillary	0
D9933	Cleaning And Inspection Of Removable Complete Denture, Mandibular	0
D9934	Cleaning And Inspection Of Removable Partial Denture, Maxillary	0
D9935	Cleaning And Inspection Of Removable Partial Denture, Mandibular	0
D9986	Missed Appointment	11
D9987	Cancelled appointment	11
D9990	Certified translation or sign-language services - per visit	0
D9991	Dental Case Management - Addressing Appointment Compliance Barriers	0
D9992	Dental Case Management - Care Coordination	0
D9993	Dental Case Management - Motivational Interviewing	0
D9994	Dental Case Management - Patient Education To Improve Oral Health Literacy	0
D9995	Teledentistry - Synchronous; Real-Time Encounter	0
D9996	Teledentistry - Asynchronous; Information Stored and Forwarded to Dentist for Subsequent Review	0
D9997	Dental care management - patients with special health care needs	0

#### FOOTNOTES

- ◆ Charges for the use of precious (high noble) or semi precious (noble) metal are not included in the copayment for crowns, bridges, pontics, inlays and onlays. The decision to use these materials is a cooperative effort between the provider and the patient, based on the professional advice of the provider. Providers are expected to charge no more than an additional \$125 for these materials.
- ✚ Please Report Under Code D8999 "Unspecified Orthodontic Procedure, By Report." Records Include All Diagnostic Procedures, Such As Cephalometric Films, Full Mouth X-Rays, Models, And Treatment Plans.

## SCHEDULE OF EXCLUSIONS AND LIMITATIONS

### EXCLUSIONS

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

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



26. For broken appointments.
27. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from

service in the national guard or in the armed forces of any country or international authority.

## LIMITATIONS

The following services, **if listed on the Schedule of Benefits**, will be subject to limitations as set forth below.

1. Bitewing x-rays –one set(s) per six consecutive months through age 13, and one set(s) of bitewing x-rays per 12 consecutive months for age 14 and older.
2. Panoramic or full mouth x-rays – one per three-year period.
3. Prophylaxis –one per 120 days.
4. Sealants – one per tooth per 120 days through age 15 on permanent first and second molars.
5. Fluoride treatment –one per 120 days through age 18.
6. Space maintainers only eligible for Members through age 18 years when used to maintain space as a result of prematurely lost deciduous first molar and deciduous second molar, or permanent first molars that have not, or will never develop.  
  
This limitation does not apply if the service was provided as a result of a standing or non-network referral as described in the Certificate of Coverage.
7. Restorations, crowns, inlays and onlays – covered only if necessary to treat diseased or fractured teeth.
8. Crowns, bridges, inlays, onlays, buildups, post and cores – one per tooth in a five-year period.
9. Crown lengthening – one per tooth per lifetime.
9. Referral for specialty care is limited to orthodontics, oral surgery, periodontics, endodontics, and pediatric dentists.  
  
This limitation does not apply if the service was provided as a result of a standing or non-network referral as described in the Certificate of Coverage.
11. Coverage for referral to a pediatric Specialty Care Dentist ends on a Member's seventh birthday.
12. Pupal therapy – through age five on primary anterior teeth and through age 11 on primary posterior teeth.
13. Root canal treatment – one per tooth per lifetime.
14. Root canal retreatment – one per tooth per lifetime.
15. Periodontal scaling and root planing – one per 24 consecutive month period per area of the mouth.
16. Surgical periodontal procedures – one per 24 consecutive month period per area of the mouth.
17. Full and partial dentures – one per arch in a five-year period.
18. Denture relining, rebasing or adjustments – are included in the denture charges if provided within six months of insertion by the same dentist.
19. Subsequent denture relining or rebasing – limited to one every 36 consecutive months thereafter.
20. Oral surgery services are limited to surgical exposure of teeth, removal of teeth, preparation of the mouth for dentures, removal of tooth generated cysts up to 1.25cm, frenectomy and crown lengthening.
21. Wisdom teeth (third molars) extracted for Members under age 15 or over age 30 are not eligible for payment in the absence of specific pathology.
22. If for any reason orthodontic services are terminated or coverage under the Company is terminated before completion of the approved orthodontic treatment, the responsibility of the Company will cease 60 days after termination if paid monthly or the later of 60 days after termination or the end of the quarter in progress if paid quarterly. This extension of orthodontic payment does not apply if coverage was terminated due to failure of the individual to pay required Premium, fraud, or material misrepresentation by the individual, or if succeeding coverage is provided by another health plan and the cost to the individual is less than or equal to the cost to the individual of coverage during the extension and there is no interruption of benefits.
23. Orthodontic treatment – not eligible for Members over age 18 unless listed otherwise in the Member's Schedule of Benefits.
24. Comprehensive orthodontic treatment plan – one per lifetime.
25. In the case of a Dental Emergency involving pain or a condition requiring immediate treatment, the Plan covers necessary diagnostic and therapeutic dental procedures administered by an Out-of-Network Dentist up to the difference between the Out-of-Network Dentist's charge and the Member Copayment up to a maximum of \$50 for each emergency visit.

26. Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bony or complete bony impactions).
27. An Alternative Benefit Provision (ABP) may be applied by the Primary Dental Office if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed for the ABP.

# DAVIS VISION: BENEFITS YOU CAN SEE

Eye health plays a big role in full-body wellness. That's why we've partnered with Davis Vision to make eye care more affordable.

Thanks to this partnership, United Concordia members can get discounted eye exams, lenses, frames and other eyewear options at more than 35,000 locations nationwide.

## Benefits Include:

- Industry's only FREE breakage warranty (12 months)
- Versant Health Hearing Savings plan—Provides members access to hearing care professionals and savings up to 60% off retail.
- Laser Vision Correction—Save up to 25% off usual and customary fees or 5% off a center's advertised special, through our network of preeminent physicians affiliated with Eye Centers of Excellence.

## How it Works

Just visit a participating vision provider, then present your discount card with control code to receive special pricing. (Complete and cut out the card on this sheet). If your current health plan already includes vision benefits, visit a network provider for the exam, then use a Davis Vision contracted provider for eyewear purchases. (Please verify that the eyewear provider accepts outside prescriptions prior to the appointment.)

## Find a Provider and Access Benefits Information

- Online**
- Visit **DavisVision.com** and select **Member**. Enter **Client Code 7602**.
  - Here you can find a provider, review benefits, access forms, buy replacement contacts and more
- By Phone**
- Call **1-877-923-2847** and enter **Client Code 7602** when prompted



## Davis Vision Discount Schedule Member Cost

### Eye Examination

Complete Examination	15% off Usual & Customary
Contact Lens Examination	15% off Usual & Customary

### Frame

Frame—up to \$70 retail	\$40
Frame—over \$70 retail	\$40 plus 10% off the amount over \$70

### Spectacle Lenses

Single Vision Lenses	\$35
Bifocal Lenses	\$55
Trifocal Lenses	\$65
Lenticular Lenses	\$110

### Options (Add to Spectacle Lenses Prices)

Standard Progressive Lenses	\$75
Premium Progressive Lenses	\$125
Polarized	\$75
High Index Lenses	\$55
Glass Lenses	\$18
Polycarbonate Lenses	\$30
Blended Invisible Bifocals	\$20
Intermediate Vision Lenses	\$30
Scratch Resistant Coating	\$15
Anti-Reflective Treatment	\$45
Ultraviolet Coating	\$15
Solid Tint	\$10
Gradient Tint	\$12
PGX Lenses	\$35
Plastic Photosensitive Lenses	\$65

### Contact Lenses

Conventional	20% off Usual & Customary
Disposable/Planned Replacement	10% off Usual & Customary

### Other Products

Non-Prescription Sunglasses	20% off Usual & Customary
Other Ancillary Products/Solutions	10% off Usual & Customary
Laser Vision Correction	Up to 25% off Usual & Customary

Note: Any special lens designs, materials, powers and frames may require additional payment.

**DAVISVISION®**  
SEE LIFE

This card entitles the bearer and family to special discounted pricing

Name \_\_\_\_\_

Group **United Concordia**

Client Code **7602**

Signature \_\_\_\_\_

*Benefits you can see.*

# ENVISION A WORLD WITH BETTER HEARING

## Your Hearing Network Savings Plan

Hearing tests are simple, painless and widely available. Get the hearing health care you and your family need through your Davis Vision plan.

### The Signs of Hearing Loss

The signs of hearing loss can be vague and develop slowly. Or they can be obvious and start suddenly. Regardless, struggling to hear certain sounds or syllables is a telltale symptom of hearing loss.

If you notice signs of hearing loss in yourself or a loved one, it's important to get help. Get started by scheduling a hearing test with Your Hearing Network Provider today.

### Start Your Hearing Health Journey

Exclusive discounts to get you started on your way to better hearing.

Hearing Exam	FREE
Trial period	60-day money-back guarantee
Follow-up care	1 Year
Warranty	4-Year service, including 1 year of loss and damage
Batteries	4-Year supply included with each hearing aid purchase



### Quality

A highly skilled network of credentialed hearing care professionals provide you with quality care.

### Savings

Get significant savings including up to 40% off premium hearing aids.

### Accessibility

The national Your Hearing Network offers licensed hearing care providers near you.

### Schedule an Appointment with a Hearing Care Professional:

Visit [davisvision.yourhearing.com](https://davisvision.yourhearing.com), or call **1-888-809-0044** to make an appointment or learn more about hearing aid discounts.

Hearing health care services administered by Your Hearing Network.



EEM-0124-1019

**UNITED CONCORDIA® DENTAL**  
Protecting More Than Just Your Smile®

United Concordia policies cover only dental benefits with an optional vision rider available. United Concordia's Group Policy begins on the agreed effective date and renews subject to the terms of the Group Policy. Either the employer/group or United Concordia may elect not to renew the Group Policy by providing written notice to the other party at least 31 days prior to renewal. United Concordia may terminate the Group Policy with 31 days written notice if the employer/group fails to pay premium. United Concordia may adjust rates or benefits or terminate the Policy on any premium due date with 31 days advance notice if the minimum participation requirements are not achieved or the nature of the risk changes significantly. Employees/members may be subject to open enrollment periods, late enrollment or voluntary disenrollment restrictions, or continuous enrollment to advance benefit level as required by the Group Policy terms. Employees/members must also meet their employer's or group's eligibility requirements or waiting period for insurance. The amount of benefits and cost depend upon the plan selected. Policy Series Number: 9802 (2/13) or 9802 (4/15). Underwritten by United Concordia Insurance Company. UCVision benefits are administered by Davis Vision, Inc. Vision discounts are not insurance and are available only from Davis Vision contracted providers. Hearing savings plan and discounts are also not insurance and are available only from EPIC Hearing contracted providers. \*Note that UCVision riders are not available for sale with DHMO products. Not all products available in all jurisdictions.