

UNITED CONCORDIA

**United Concordia  
Dental Plans, Inc.**

*4401 Deer Path Road  
Harrisburg, PA 17110*

**Dental Plan  
Certificate of Coverage**

# **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 for You and any enrolled Dependents 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

**TABLE OF CONTENTS**

DEFINITIONS ..... 3  
ELIGIBILITY AND ENROLLMENT ..... 5  
HOW THE DENTAL PLAN WORKS..... 6  
BENEFITS ..... 8  
ALTERNATE TREATMENT ..... 9  
WORKER'S COMPENSATION & OTHER GOVERNMENTAL PROGRAMS..... 11  
TERMINATION..... 12  
CONTINUATION OF COVERAGE ..... 12  
CONVERSION OF COVERAGE..... 13  
GENERAL PROVISIONS ..... 13

ATTACHED:

- APPEAL PROCEDURE ADDENDUM
- SCHEDULE OF BENEFITS
- SCHEDULE OF EXCLUSIONS AND LIMITATIONS

## DEFINITIONS

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

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

**Certificate of 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** - The United Concordia Dental Plan indicated on the cover page of this Certificate. Also referred to as "We", "Our" or "Us".

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

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

**Copayments** - Those amounts set forth in the Schedule of Benefits that the Certificate Holder or his/her enrolled Dependents are 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)** - A service or supply specified in the Schedule of Benefits for which benefits will be covered subject to the Schedule of Exclusions and Limitations, when rendered by 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.

**Dependent(s)** - Certificate Holder's enrolled spouse and any enrolled child, adoptive child, stepchild, or grandchild of a Certificate Holder, or an enrolled child subject to a court order or placed by an administrative agency with a Certificate Holder:

- (a) until the end of the month the child reaches the limiting age of 26; or
- (b) to any age beyond the limiting age listed above if the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical incapacity and chiefly dependent upon the Certificate Holder for maintenance and support.

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

**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.

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

**Group Contract** - The agreement between the Company and the Contractholder, under which the Certificate Holder is eligible to enroll.

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

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

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

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

**Out-of-Network Dentist** - A general or specialty care dentist who has not signed a contract with the Company or an affiliate of the Company.

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

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

**Primary Dental Office** - Approved office of a Primary Dentist who has executed a contract with the Company or its affiliates and who offers dental services to Members.

**Primary Dentist** - A general dentist whose office has executed a contract with the Company or its affiliates, under which he/she agrees to provide those dental services listed in the Schedule of Benefits 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 applicable to benefits payable under the Plan.

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

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

**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 the Company to accept negotiated fees plus any applicable Copayments, as payment in full for Covered Services provided to Members.

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

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

### **New Enrollment**

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

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

You must supply the required enrollment information on Yourself and Your Dependents within 31 days of the date You meet these requirements. Your Dependents must also meet the requirements detailed in the definition of Dependent in the Definitions section of this Certificate.

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

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

### **Enrollment Changes**

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

- birth of a child;
- adoption of a child;
- court order of placement or custody of a child;
- marriage of the Certificate Holder;

To enroll a new Dependent as a result of one of these events, You must notify Your Group and supply the required enrollment change information within 31 days of the date You acquired the Dependent. The Dependent must meet the requirements detailed in the definition of Dependent in the Definitions section of this Certificate.

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

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

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

For an enrolled Dependent child who is mentally or physically incapacitated, evidence of his/her reliance on You for maintenance and support due to his/her condition must also be supplied to Us within 30 days after said Dependent attains the limiting age shown in the definition of Dependent.

Such evidence will be requested based on information provided by the Member's physician but no more frequently than annually.

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

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

### **Late Enrollment**

If You or Your Dependents are not enrolled within 31 days of initial eligibility or a life change event, You or Your Dependents cannot enroll until the next open enrollment period conducted for Your Group unless otherwise required by applicable state or federal law or permitted by Your Group under the rules of its benefit plans. If You are required to provide coverage for a Dependent child pursuant to a court order, You will be permitted to enroll the Dependent child without regard to enrollment season restrictions.

### **Voluntary Disenrollment**

If You chose to drop Your coverage or Your Dependents' coverage under the Plan at any time during the contract year other than at open enrollment, You will not be permitted to enroll Yourself or Your Dependents at a later time unless You supply proof of loss of coverage under another dental plan or You or Your Dependents are eligible for a special enrollment period required by applicable state or federal law or permitted by Your Group under the rules of its benefit plans. The loss of coverage must be due to a valid life change event such as death, divorce or change in employment status of spouse. If You supply such proof, You will be permitted to re-enroll at the next open enrollment period. You will be considered a new enrollee with respect to application of any Waiting Periods or benefit level changes shown on the Schedule of Benefits.

## **HOW THE DENTAL PLAN WORKS**

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

When You enroll for dental coverage, You must select a Primary Dental Office for Yourself and Your Dependents. Your Dependents do not have to choose the same office as You choose. If You or Your Dependents do not select an office at enrollment, We may assign You to an office in a location convenient to Your home zip code. The Primary Dental Offices will be notified of Your selection or assignment.

To find a Primary Dental Office, visit *Find a Dentist* on Our website at [www.unitedconcordia.com](http://www.unitedconcordia.com) or call Our Interactive Voice Response System at the toll-free number in the Introduction section of this Certificate.

Once enrolled, You will receive an ID Card or other notification indicating the names of the Primary Dental offices You and Your Dependents selected or that were assigned by Us, Your contract ID number, plan number and Group number. When You call the office to schedule an appointment, let the office know You have United Concordia coverage. When You visit the dental office, present Your ID card or let the office know Your ID number, Plan number and Group number. If Your dentist has questions about Your eligibility or benefits, instruct the office to call Our Interactive Voice Response System toll-free or visit *My Patients' Benefits* on Our website at [www.unitedconcordia.com](http://www.unitedconcordia.com).

### **Changing Providers**

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

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

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

The Primary Dental Office will coordinate dental care for You and Your Dependents. There are no claim forms required from You. In order for dental services to be covered, care must be provided by Your assigned Primary Dentist, or by a Specialty Care Dentist to whom You have a written referral from Your Primary Dentist. The exceptions are if You have a Dental Emergency 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 section entitled Dental Emergencies and Out-of-Network Care 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.

### **Standing Referral Guidelines**

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 include a narrative on the necessity of the standing referral.

You should take the *Specialty Referral/Claim Form* to the Specialty Care Dentist at the initial appointment. A standing referral is made in accordance with a written treatment plan for Your covered services by the Specialty Care Dentist and the Primary Dental Office. The Specialty Care Dentist provides treatment at each appointment and submits a copy of the *Specialty Referral/Claim Form* to the company. For standing referrals, You are not required to see his Primary Dental Office prior to appointments with the Specialty Care Dentist.

### **Out-of-Network Referral Guidelines**

The Company will allow You a referral of a Member 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;
- 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 non-Specialty Care Dentist. The referral should include a narrative on the necessity of specialized care to a non-Specialty Care Dentist. The Primary Dental Office should contact Customer Service to notify the Company of a referral to a non-Specialty Care Dentist and to receive the authorization number.

You should take the *Specialty Referral/Claim Form* to the non-Specialty Care Dentist. The Specialty Care Dentist 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 *My Dental Benefits* at [www.unitedconcordia.com](http://www.unitedconcordia.com).

### **Dental Emergencies and Out-of-Network Care**

There are situations when You may receive a benefit for Covered Services performed by an Out-of-Network Dentist. When immediate dental treatment is required as a result of a Dental Emergency and You are more than 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 obtain 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.

The second situation is when a Specialty Care Dentist is not available within a 30-mile radius of Your home. In this situation, We may arrange a visit to 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. Your out-of-pocket cost will be limited to the Copayment listed on the Schedule of Benefits as long as the dental procedure is covered under the Plan.

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**

### **Schedule of Benefits**

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

- the dental procedures covered under the Plan
- the Copayment for each procedure which You are responsible to pay Your Primary Dentist or Specialty Care Dentist

### **Your Out-of-Pocket Costs**

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 under the Plan. 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 the uncovered service.

Second, certain procedures listed on the Schedule of Benefits require a Copayment from You. 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 dental office. 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.

Last, services listed on the Schedule of Benefits are also subject to Exclusions and Limitations. Be sure to review the Schedule of Exclusions and Limitations also attached to this Certificate.

### **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.

### **Exclusions and Limitations**

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

### **Payment of Benefits**

We will pay covered benefits directly to Your assigned Primary Dental Office or the Specialty Care Dentist. Payment is based on allowances contracted with In-Network Dentists. All contracts between the Company and the In-Network Dentists state that under no circumstances will the Member be liable to any dentists for any sum owed by the Company to the dentists. In any instance where the Company fails or refuses to pay the dentists, such dispute is solely between the dentists and the Company, and the Member is not liable for any monies the Company fails or refuses 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 determination of the impossibility of providing services by In-Network Dentists.

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

### **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.
  - C) Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:
    - 1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
    - 2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
    - 3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
    - 4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of

benefits, the rule based upon the gender of the parent will determine the order of benefits.

- D) Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:
- 1) First, the plan of the parent with custody of the child.
  - 2) Then, the plan of the spouse of the parent with the custody of the child; and
  - 3) Finally, the plan of the parent not having custody of the child.
  - 4) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
  - 5) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 3-C) above, titled Dependent Child/Parents Not Separated or Divorced.
- E) Active/Inactive Member
- 1) For actively employed Members and their spouses over the age of 65 who are covered by Medicare, the plan will be primary.
  - 2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.
- F) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary.
- G) The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a Member or a Dependent.

4. Right to Receive and Release Needed Information -- Certain facts are needed to apply these COB rules. The Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Any health information furnished to a third party will be released in accordance with 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. If, after speaking with a Customer Service representative, You are still dissatisfied, refer to the Appeal Procedure Addendum attached to this Certificate for further steps You can take regarding Your claim.

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

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

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

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

Services for orthodontic treatment will continue for 60 days after coverage termination if the orthodontist has agreed to or is receiving monthly payments; or until the later of 60 days after coverage termination 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 failure to pay required Premium; fraud, or if succeeding coverage is provided by another health plan and the cost is less than or equal to the cost of coverage during the extension and there is no interruptions of benefits.

If Your coverage ends, Your Dependents' coverage will end on the same date. If the Group Contract is cancelled, Your coverage and Your Dependents' coverage will end on the Group Contract Termination Date. The Primary Dental Office or Specialty Care Dentist shall 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 shall inform the Member of the charge for any scheduled dental services before performing the dental services.

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

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

### **CONTINUATION COVERAGE**

Federal 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. You should contact Your employer to find out whether or not this requirement applies to You and Your employer. Your employer will advise You of Your rights to continuation coverage and the cost. If this requirement does apply, You must elect to continue coverage within 60 days from Your qualifying event or notification of rights by Your employer, whichever is later. You may elect to extend Dependent(s) coverage, or the Dependent(s) may elect to continue coverage under certain circumstances or qualifying events. Dependent(s) must elect to continue coverage within

60 days from the event or notification of rights by Your employer, whichever is later. You must pay the required premium for continuation coverage directly to Your employer. The Company is not responsible for determining who is eligible for continuation coverage.

### **CONVERSION OF COVERAGE**

The Company allows You and Your Dependents to continue Your coverage without evidence of insurability. Under a Conversion Certificate of Coverage, if You or Your Dependent(s) coverage under the Group Contract ends for any reason other than the following: (a) failure to pay any required contribution toward the cost of the dental benefits; or (b) disenrollment by the Company due to Member fraud in the use of dental services or facilities; or (c) change of residence to an area outside the State of Maryland, to convert coverage, You or Your Dependent(s) must make written application for Yourself and/or Your Dependent(s) and pay the first three month's Premium to the Company within 30 days after termination of Your and/or Your Dependent's coverage under this Certificate. Coverage under the Conversion Certificate of Coverage becomes effective on the date the coverage under this Certificate terminates.

### **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 subject matter. The failure of any section or subsection of this Certificate shall not affect the validity, legality and enforceability of the remaining sections.

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

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

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



## **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 866-357-3304, 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.

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

**"Appeal"** is a protest filed by You, Your Authorized Representative or a dental 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 an Adverse Benefit Determination. An assignment of benefits is not a grant of authority to act on Your behalf in pursuing an Appeal for an Adverse Benefit Determination.

**"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.

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.

### **Procedure**

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

We will review the claim and notify You of Our decision within sixty (60) 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.

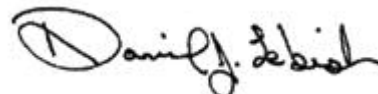
The final decision will include a written notice of the Appeal decision. Written notice of the Appeal decision will be sent within thirty (30) calendar days of the Appeal decision to You or Your Authorized Representative and the Health Care Provider acting on Your behalf. The notice of the Appeal decision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

### **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.



---

Authorized Officer

**FEDERAL LAW SUPPLEMENT  
TO  
CERTIFICATE OF INSURANCE**

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

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

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

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

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



# United Concordia

## Rider to Schedule of Benefits and Schedule of Exclusions and Limitations

### Maternity Dental Benefit

This Rider is effective on January 1, 2012 and is attached to and made a part of the Schedules of Benefits and Schedule of Exclusions and Limitations.

#### **SCHEDULE OF EXCLUSIONS AND LIMITATIONS:**

The following limitation is substituted for the limitation on prophylaxis in the Schedule of Exclusions and Limitations:

Prophylaxis – one (1) per six consecutive months, unless otherwise specified in the Schedule of Benefits. One additional Prophylaxis in a twelve consecutive month period for Members under the care of a medical professional for pregnancy.

#### **SCHEDULE OF BENEFITS:**

Member Copayments on the Schedule of Benefits shall apply to the additional prophylaxis provided to a Member under the care of a medical professional for pregnancy.

UNITED CONCORDIA DENTAL PLANS, INC.



---

Authorized Officer



**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**.

ADA CODE	ADA DESCRIPTION	Member Pays \$	ADA CODE	ADA DESCRIPTION	Member Pays \$
<b>CLINICAL ORAL EVALUATIONS</b>			<b>SPACE MAINTENANCE</b> <b>(passive appliances)</b>		
D0120	Periodic oral evaluation - established patient	0	D1510	Space maintainer - fixed - unilateral	0
D0140	Limited oral evaluation - problem focused	0	D1515	Space maintainer - fixed - bilateral	0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0	D1520	Space maintainer - removable - unilateral	0
D0150	Comprehensive oral evaluation - new or established patient	0	D1525	Space maintainer - removable - bilateral	0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	0	D1550	Re-cementation of space maintainer	0
D0180	Comprehensive periodontal evaluation - new or established patient	0	D1555	Removal of fixed space maintainer	0
<b>RADIOGRAPHS/DIAGNOSTIC IMAGING</b> <b>(including interpretation)</b>			<b>AMALGAM RESTORATIONS</b> <b>(including polishing)</b>		
D0210	Intraoral - complete series (including bitewings)	0	D2140	Amalgam - one surface, primary or permanent	0
D0220	Intraoral - periapical first film	0	D2150	Amalgam - two surfaces, primary or permanent	0
D0230	Intraoral - periapical each additional film	0	D2160	Amalgam - three surfaces, primary or permanent	0
D0240	Intraoral - occlusal film	0	D2161	Amalgam - four or more surfaces, primary or permanent	0
D0270	Bitewing - single film	0	<b>RESIN-BASED COMPOSITE RESTORATIONS - DIRECT</b>		
D0272	Bitewings - two films	0	D2330	Resin-based composite - one surface, anterior	0
D0273	Bitewings - three films	0	D2331	Resin-based composite - two surfaces, anterior	0
D0274	Bitewings - four films	0	D2332	Resin-based composite - three surfaces, anterior	0
D0277	Vertical bitewings - 7 to 8 films	0	D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	0
D0330	Panoramic film	0	D2390	Resin-based composite crown, anterior	0
D0340	Cephalometric film	0	D2391	Resin-based composite - one surface, posterior	31
<b>TESTS AND EXAMINATIONS</b>			D2392	Resin-based composite - two surfaces, posterior	43
D0460	Pulp vitality tests	0	D2393	Resin-based composite - three surfaces, posterior	54
D0470	Diagnostic casts	0	D2394	Resin-based composite - four or more surfaces, posterior	58
<b>DENTAL PROPHYLAXIS</b>			<b>INLAY/ONLAY RESTORATIONS</b>		
D1110	Prophylaxis - adult	0	D2510	Inlay - metallic - one surface	100 ♦
D1120	Prophylaxis - child	0	D2520	Inlay - metallic - two surfaces	161 ♦
<b>TOPICAL FLUORIDE TREATMENT</b> <b>(office procedure)</b>			D2530	Inlay - metallic - three or more surfaces	171 ♦
D1203	Topical application of fluoride - child	0	D2542	Onlay - metallic - two surfaces	190 ♦
D1204	Topical application of fluoride - adult	0	D2543	Onlay - metallic - three surfaces	190 ♦
D1206	Topical fluoride varnish; therapeutic application for moderate to high risk patients	0	D2544	Onlay - metallic - four or more surfaces	196 ♦
<b>OTHER PREVENTIVE SERVICES</b>			<b>CROWNS - SINGLE RESTORATIONS ONLY</b>		
D1330	Oral hygiene instructions	0	D2710	Crown - resin-based composite (indirect)	87
D1351	Sealant - per tooth	0	D2712	Crown - 3/4 resin-based composite (indirect)	87
			D2740	Crown - porcelain/ceramic substrate	220
			D2750	Crown - porcelain fused to high noble metal	215 ♦
			D2751	Crown - porcelain fused to predominantly base metal	207

ADA CODE	ADA DESCRIPTION	Member Pays \$	ADA CODE	ADA DESCRIPTION	Member Pays \$
D2752	Crown - porcelain fused to noble metal	211◆			
D2780	Crown - 3/4 cast high noble metal	212◆			
D2781	Crown - 3/4 cast predominantly base metal	194			
D2782	Crown - 3/4 cast noble metal	202◆			
D2783	Crown - 3/4 porcelain/ceramic	220			
D2790	Crown - full cast high noble metal	212◆			
D2791	Crown - full cast predominantly base metal	194			
D2792	Crown - full cast noble metal	202◆			
D2794	Crown - titanium	207			
D2799	Provisional crown	0			
<b>OTHER RESTORATIVE SERVICES</b>			<b>APICOECTOMY/PERIRADICULAR SERVICES</b>		
D2910	Recement inlay, onlay, or partial coverage restoration	0	D3410	Apicoectomy/periradicular surgery - anterior	132
D2915	Recement cast or prefabricated post and core	0	D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	143
D2920	Recement crown	0	D3425	Apicoectomy/periradicular surgery - molar (first root)	156
D2930	Prefabricated stainless steel crown - primary tooth	0	D3426	Apicoectomy/periradicular surgery (each additional root)	60
D2931	Prefabricated stainless steel crown - permanent tooth	0	D3430	Retrograde filling - per root	10
D2940	Protective restoration	0	D3450	Root amputation - per root	85
D2950	Core buildup, including any pins	0	<b>OTHER ENDODONTIC PROCEDURES</b>		
D2951	Pin retention - per tooth, in addition to restoration	0	D3920	Hemisection (including any root removal), not including root canal therapy	74
D2952	Post and core in addition to crown, indirectly fabricated	0	D3950	Canal preparation and fitting of preformed dowel or post	0
D2953	Each additional indirectly fabricated post - same tooth	0	<b>SURGICAL SERVICES</b>		
D2954	Prefabricated post and core in addition to crown	0	<b>(including usual postoperative care)</b>		
D2957	Each additional prefabricated post - same tooth	0	D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	92
D2970	Temporary crown (fractured tooth)	52	D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	30
D2971	Additional procedures to construct new crown under existing partial denture framework	25	D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	88
<b>PULP CAPPING</b>			D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	35
D3110	Pulp cap - direct (excluding final restoration)	0	D4245	Apically positioned flap	150
D3120	Pulp cap - indirect (excluding final restoration)	0	D4249	Clinical crown lengthening - hard tissue	111
<b>PULPOTOMY</b>			D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	197
D3220	Therapeutic pulpotomy (excluding final restoration)	0	D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	79
D3221	Pulpal debridement, primary and permanent teeth	0	D4263	Bone replacement graft - first site in quadrant	98
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0	D4264	Bone replacement graft - each additional site in quadrant	99
<b>ENDODONTIC THERAPY ON PRIMARY TEETH</b>			D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	46
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0	<b>NON-SURGICAL PERIODONTAL SERVICES</b>		
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0	D4341	Periodontal scaling and root planing - four or more teeth per quadrant	0
<b>ENDODONTIC THERAPY</b>			D4342	Periodontal scaling and root planing - one to three teeth per quadrant	0
<b>(including treatment plan, clinical procedures and follow-up care)</b>			D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	0
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	0	D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, per report	100
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	0	<b>OTHER PERIODONTAL SERVICES</b>		
D3330	Endodontic therapy, molar (excluding final restoration)	193	D4910	Periodontal maintenance	0
<b>ENDODONTIC RETREATMENT</b>			<b>COMPLETE DENTURES</b>		
D3346	Retreatment of previous root canal therapy - anterior	0	<b>(including routine post-delivery care)</b>		
D3347	Retreatment of previous root canal therapy - bicuspid	0	D5110	Complete denture - maxillary	266
D3348	Retreatment of previous root canal therapy - molar	212	D5120	Complete denture - mandibular	266
			D5130	Immediate denture - maxillary	282
			D5140	Immediate denture - mandibular	282

ADA CODE	ADA DESCRIPTION	Member Pays \$	ADA CODE	ADA DESCRIPTION	Member Pays \$
<b>PARTIAL DENTURES</b> (including routine post-delivery care)					
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	213	D6214	Pontic - titanium	194
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	220	D6240	Pontic - porcelain fused to high noble metal	215◆
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	282	D6241	Pontic - porcelain fused to predominantly base metal	207
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	282	D6242	Pontic - porcelain fused to noble metal	211◆
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	324	D6245	Pontic - porcelain/ceramic	220
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	324	<b>FIXED PARTIAL DENTURE RETAINERS - CROWNS</b>		
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	158	D6710	Crown - indirect resin based composite	220
<b>ADJUSTMENTS TO DENTURES</b>			D6740	Crown - porcelain/ceramic	220
D5410	Adjust complete denture - maxillary	14	D6750	Crown - porcelain fused to high noble metal	215◆
D5411	Adjust complete denture - mandibular	14	D6751	Crown - porcelain fused to predominantly base metal	207
D5421	Adjust partial denture - maxillary	14	D6752	Crown - porcelain fused to noble metal	211◆
D5422	Adjust partial denture - mandibular	14	D6780	Crown - 3/4 cast high noble metal	210◆
<b>REPAIRS TO COMPLETE DENTURES</b>			D6781	Crown - 3/4 cast predominantly base metal	194
D5510	Repair broken complete denture base	27	D6782	Crown - 3/4 cast noble metal	202◆
D5520	Replace missing or broken teeth - complete denture (each tooth)	28	D6783	Crown - 3/4 porcelain/ceramic	220
<b>REPAIRS TO PARTIAL DENTURES</b>			D6790	Crown - full cast high noble metal	212◆
D5610	Repair resin denture base	26	D6791	Crown - full cast predominantly base metal	194
D5620	Repair cast framework	29	D6792	Crown - full cast noble metal	202◆
D5630	Repair or replace broken clasp	32	D6794	Crown - titanium	194
D5640	Replace broken teeth - per tooth	24	<b>OTHER FIXED PARTIAL DENTURE SERVICES</b>		
D5650	Add tooth to existing partial denture	30	D6930	Recement fixed partial denture	0
D5660	Add clasp to existing partial denture	36	D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	64
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	183	D6972	Prefabricated post and core in addition to fixed partial denture retainer	55
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	183	D6973	Core build up for retainer, including any pins	46
<b>DENTURE REBASE PROCEDURES</b>			D6976	Each additional indirectly fabricated post - same tooth	0
D5710	Rebase complete maxillary denture	81	D6977	Each additional prefabricated post - same tooth	0
D5711	Rebase complete mandibular denture	81	<b>EXTRACTIONS</b> (includes local anesthesia, suturing, if needed, and routine postoperative care)		
D5720	Rebase maxillary partial denture	95	D7111	Extraction, coronal remnants - deciduous tooth	0
D5721	Rebase mandibular partial denture	95	D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0
<b>DENTURE RELINE PROCEDURES</b>			<b>SURGICAL EXTRACTIONS</b> (includes local anesthesia, suturing, if needed, and routine postoperative care)		
D5730	Reline complete maxillary denture (chairside)	52	D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	45
D5731	Reline complete mandibular denture (chairside)	52	D7220	Removal of impacted tooth - soft tissue	56
D5740	Reline maxillary partial denture (chairside)	48	D7230	Removal of impacted tooth - partially bony	75
D5741	Reline mandibular partial denture (chairside)	48	D7240	Removal of impacted tooth - completely bony	89
D5750	Reline complete maxillary denture (laboratory)	77	D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	90
D5751	Reline complete mandibular denture (laboratory)	77	D7250	Surgical removal of residual tooth roots (cutting procedure)	45
D5760	Reline maxillary partial denture (laboratory)	81	D7251	Coronectomy – intentional partial tooth removal	89
D5761	Reline mandibular partial denture (laboratory)	81	<b>OTHER SURGICAL PROCEDURES</b>		
<b>OTHER REMOVABLE PROSTHETIC SERVICES</b>			D7280	Surgical access of an unerupted tooth	86
D5850	Tissue conditioning, maxillary	0	D7283	Placement of device to facilitate eruption of impacted tooth	22
D5851	Tissue conditioning, mandibular	0	D7288	Brush biopsy - transepithelial sample collection	45
<b>FIXED PARTIAL DENTURE PONTICS</b>			<b>ALVEOLOPLASTY</b> (surgical preparation of ridge for dentures)		
D6205	Pontic - indirect resin based composite	220	D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	46
D6210	Pontic - cast high noble metal	212◆			
D6211	Pontic - cast predominantly base metal	194			
D6212	Pontic - cast noble metal	202◆			

ADA CODE	ADA DESCRIPTION	Member Pays \$	ADA CODE	ADA DESCRIPTION	Member Pays \$
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	59	<b>PROFESSIONAL VISITS</b>		
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	24	D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	0
<b>SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS</b>			D9440	Office visit, after regularly scheduled hours	43
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	75	<b>MISCELLANEOUS SERVICES</b>		
<b>OTHER REPAIR PROCEDURES</b>			★	Broken appointment per 15 minutes (without 24-hour notice)	10
D7960	Frenulectomy – also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	68	<b>FOOTNOTES</b>		
D7963	Frenuloplasty	34	†	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.	
<b>LIMITED ORTHODONTIC TREATMENT</b>			★	Please report under code D9999 “Unspecified adjunctive procedure, by report.”	
D8010	Limited orthodontic treatment of the primary dentition	750	◆	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.	
D8020	Limited orthodontic treatment of the transitional dentition	750			
D8030	Limited orthodontic treatment of the adolescent dentition	750			
D8040	Limited orthodontic treatment of the adult dentition	750			
<b>INTERCEPTIVE ORTHODONTIC TREATMENT</b>					
D8050	Interceptive orthodontic treatment of the primary dentition	900			
D8060	Interceptive orthodontic treatment of the transitional dentition	900			
<b>COMPREHENSIVE ORTHODONTIC TREATMENT</b>					
D8070	Comprehensive orthodontic treatment of the transitional dentition	1,900			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	2,100			
D8090	Comprehensive orthodontic treatment of the adult dentition	2,300			
<b>MINOR TREATMENT TO CONTROL HARMFUL HABITS</b>					
D8210	Removable appliance therapy	212			
D8220	Fixed appliance therapy	222			
<b>OTHER ORTHODONTIC SERVICES</b>					
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	400			
†	Orthodontic records fee	350			
<b>UNCLASSIFIED TREATMENT</b>					
D9110	Palliative (emergency) treatment of dental pain - minor procedure	0			
<b>ANESTHESIA</b>					
D9220	Deep sedation/general anesthesia - first 30 minutes	200			
D9221	Deep sedation/general anesthesia - each additional 15 minutes	40			
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	200			
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	40			
<b>PROFESSIONAL CONSULTATION</b>					
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	30			

## SCHEDULE OF EXCLUSIONS AND LIMITATIONS

### EXCLUSIONS

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

1. Not specifically listed in the Schedule of Benefits as a Covered Service.
2. Provided to Members outside of the Primary Dental Office in which the Member is enrolled and services provided by a Specialty Care Dentist without a referral except for emergency services as specified in the Certificate.
3. Which in the opinion of the treating dentist, or the Company, are not clinically necessary, or do not have a reasonable, favorable prognosis.
4. That are necessary due to lack of cooperation with the treating dentist, or failure to comply with a professionally prescribed Treatment Plan.
5. Started or incurred prior to the Member's Effective Date with the Company or after the Termination Date of Coverage with the Company.
6. For consultations by a Specialty Care Dentist for services not specifically listed on the Schedule of Benefits as a Covered Service.
7. Services or supplies that are not deemed generally accepted standards of dental treatment.
8. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy. 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.

For Group Contracts and Certificates issued and delivered in Missouri and New Jersey, only services that are the responsibility of Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

For Group Contracts and Certificates issued and delivered in Texas, only services that are the responsibility of the employer's liability insurance, or for treatment of any automobile related injury shall be excluded from this Plan.

For Group Contracts and Certificates issued and delivered in Florida, only services that are paid by Workers' Compensation or the employer's liability insurance, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy shall be excluded from this Plan.

9. For services and/or appliances that alter the vertical dimension or alter, restore or maintain the occlusion, including, but not limited to, full mouth rehabilitation, splinting, appliances or any other method.

This exclusion does not apply to Group Contracts and Certificates issued in Pennsylvania if the dental condition is as a result of an accidental injury.

10. That restore tooth structure lost due to attrition, erosion or abrasion.
11. Periodontal splinting of teeth by any method.
12. For replacement of lost, missing, stolen or damaged prosthetic device or orthodontic appliance or for duplicate dentures, prosthetic devices or any duplicative device.
13. 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.
14. For implants, surgical insertion and/or removal of, and any appliances and/or crowns attached to implants.
15. 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, orthodontic appliances, bite plates, functional appliances or palatal expanders), myofunctional therapy, cases involving orthognathic surgery, extractions for orthodontic purposes, and treatment in excess of 24 months.

For Group Contracts and Certificates issued in Florida, this exclusion does not apply to diagnostic and surgical dental (not medical) procedures for treatment of TMD rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease, or injury and such procedures are covered under a Rider to the Certificate or the Schedule of Benefits.

16. For prescription or non-prescription drugs, home care items, vitamins or dietary supplements.
17. For hospitalization and associated costs for rendering services in a hospital.

18. Which are Cosmetic in nature as determined by the Company, including, but not limited to bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures.

This exclusion does not apply to Group Contracts and Certificates issued and delivered in Pennsylvania for Cosmetic services required as the result of an accidental injury.

This exclusion does not apply to Group Contracts and Certificates issued and delivered in New Jersey for Cosmetic services for newly-born children of Members as defined in the definition of Dependent.

19. 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 every three years.
3. Prophylaxis – one in a six consecutive month period, unless otherwise specified in the Schedule of Benefits.
4. Routine prophylaxis and periodontal maintenance procedures are limited to no more than any combination of one per six consecutive month period.
5. Sealants – one per tooth per three year(s) through age 15 on permanent first and second molars.
6. Fluoride treatment – one per six consecutive months through age 18.
7. Restorations, crowns, inlays and onlays – covered only if necessary to treat diseased or fractured teeth.
8. Referral to a Specialty Care Dentist is limited to orthodontics, oral surgery, periodontics, endodontics, and pediatric dentists.
9. Coverage for referral to a pediatric Specialty Care Dentist ends on a Member's seventh birthday.
10. Crown lengthening – one per tooth per lifetime.
11. Pulpal therapy – through age five on primary anterior teeth and through age 11 on primary posterior teeth.
12. Root canal treatment – one per tooth per lifetime.
13. Root canal retreatment – one per tooth per lifetime.
14. Periodontal scaling and root planing – one per 24 consecutive month period per area of the mouth.
15. Surgical periodontal procedures – one per 24 consecutive month period per area of the mouth.
16. Full and partial dentures – one per arch in a five-year period.
17. Denture relining or rebasing – integral if provided within six months of insertion by the same dentist. This limitation does not apply to immediate dentures.
18. Subsequent denture relining or rebasing – limited to one every 36 consecutive months thereafter.
19. Wisdom teeth (third molars) extracted for a Member under age 15 or over age 30 are not eligible for payment in the absence of specific pathology.
20. Members must remain in the Plan during the period of time they are undergoing orthodontic treatment. Any early termination can result in additional charges for all unfinished work.
21. Comprehensive orthodontic treatment – one per lifetime.
22. 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).
23. In the case of a Dental Emergency involving pain or a condition requiring immediate treatment occurring more than fifty (50) miles from the Member's home, the Plan covers necessary diagnostic and therapeutic dental procedures administered by a dentist up to a maximum of \$100 for each emergency visit.

This limitation does not apply to Group Contracts and Certificates issued and delivered in Arizona, California and Texas.



# DAVIS VISION *Benefits You Can See*

## 1. DISCOUNT PROGRAM

Davis Vision is pleased to provide you with a low-cost, traditional vision Discount Program that provides significant discounts on eye exams, lenses, frames and additional eyewear options. Simply visit a participating vision provider and present your discount card and Control Code. With nearly 26,000 participating vision providers, you can find a provider near you by calling our toll-free Interactive Voice Response (IVR) system or visiting the Davis Vision website at [www.davisvision.com](http://www.davisvision.com). For more details, see the Accessing Benefit and Provider Information section on the reverse side.

The Discount Program entitles you to the following discounts off usual and customary fees:

<b>Vision Plan:</b>	Vantage Affinity Discount Program
<b>Control Code/Client Control Number:</b>	7602
<b>Co-payment:</b>	N/A, discount plan is 100% member paid at the time of service
<b>Lens 123®:</b>	Discounts on replacement contact lenses from 1-800-LENS123
<b>Laser Vision Correction:</b>	Discounts from participating laser vision providers

### 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 \$70.00 retail	\$40.00
Frame—over \$70.00 retail	\$40.00 plus 10% off the amount over \$70.00

#### Spectacle Lenses

Single Vision Lenses	\$35.00
Bifocal Lenses	\$55.00
Trifocal Lenses	\$65.00
Lenticular Lenses	\$110.00

#### Options (Add to Spectacle Lenses Prices)

Standard Progressive Lenses	\$75.00
Premium Progressive Lenses	\$125.00
Polarized	\$75.00
High Index Lenses	\$55.00
Glass Lenses	\$18.00
Polycarbonate Lenses	\$30.00
Blended Invisible Bifocals	\$20.00
Intermediate Vision Lenses	\$30.00
Scratch Resistant Coating	\$15.00
Anti-Reflective Treatment	\$45.00
Ultraviolet Coating	\$15.00
Solid Tint	\$10.00
Gradient Tint	\$12.00
PGX Lenses	\$35.00
Plastic Photosensitive Lenses	\$65.00

#### Contact Lenses

Conventional	20% off Usual & Customary
Disposable/Planned Replacement	10% off Usual & Customary
Lens 123®	Free membership with up to 60% off Retail Prices

Discount Schedule continued . . .



This card entitles the bearer and family to special discounted pricing

Name \_\_\_\_\_

Group United Concordia

Control Code 7602

Signature \_\_\_\_\_



*Benefits you can see.*

Discount Schedule continued . . .

### 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.

## 2. LENS 123®

Lens 123® is a mail order program that allows you to enjoy the guaranteed lowest prices on replacement contact lenses—save up to 60% off retail prices. Members can conveniently call 1-800-LENS123 with a current prescription for this value-added service. The Lens 123® contact lens replacement program is endorsed by the industry's major manufacturers.

## 3. LASER VISION CORRECTION

Davis Vision's Laser Vision Correction program provides substantial discounts on laser vision correction procedures. Members are entitled to savings of up to 25% off usual and customary fees or a 5% discount off a center's advertised special through a network of preeminent physicians affiliated with Eye Centers of Excellence. (Some centers provide a flat fee equating to these discount levels.) See below for information on finding a participating laser vision provider near you.

### HOW THE DISCOUNT PROGRAM WORKS WITH YOUR PLAN

You may choose from a list of Davis Vision contracted private practice providers or contracted retail locations for discounts on eyewear. If you already have a vision examination benefit as part of your health plan, you may use a network provider in your health plan network for your examination. Then use a Davis Vision contracted provider for your eyewear purchases (eyeglasses, etc.) and maximize your savings (you should verify whether or not the Davis Vision provider accepts outside prescriptions prior to your appointment).

### ACCESSING BENEFIT AND PROVIDER INFORMATION

Whether you're looking for a participating vision provider or want more information about the discount plan, Davis Vision offers a number of convenient ways for you to get the information you need, when you need it.

#### AUTOMATED SERVICES (available 24/7)

**Online**—To access the United Concordia Davis Vision Discount Member Menu, visit [www.davisvision.com](http://www.davisvision.com) and select "Find a Provider". In the second box, enter Control Code 7602 and click "Submit". From the Member Menu you can find a provider, review your benefits, obtain a confirmation number for laser surgery, take a satisfaction survey, visit Lens 123® to buy replacement contact lenses and more!

**Over the phone**—To access the automated Interactive Voice Response (IVR) system, call Davis Vision Customer Service at **1-877-923-2847** and enter Client Control Number 7602 when prompted. Select the appropriate menu option using your phone's touch pad.

#### CUSTOMER SERVICE

To speak with a customer service representative, call Davis Vision Customer Service at 1-877-923-2847. Enter Client Control Number 7602 when prompted. At the main menu, press "0". Our representatives are available to assist you from 8 a.m. to 11 p.m. ET Monday through Friday, 9 a.m. to 4 p.m. ET Saturday and 12 p.m. to 4 p.m. ET Sunday.



**CUSTOMER SERVICE**  
**1-877-923-2847**

**UNITED CONCORDIA**  
Insuring America's Dental Health

