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. 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 للغوية 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 of California, Inc.

21700 Oxnard Street, Suite 500
Woodland Hills, CA 91367
800-937-6432
www.unitedconcordia.com

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

This Combined Evidence of Coverage and Disclosure Form ("Evidence of Coverage") constitutes only a summary of this dental Plan. Consult the Group Contract for the exact terms and conditions of coverage. A specimen copy of the Plan contract will be furnished on request.

The Evidence of Coverage discloses the terms and conditions of coverage. The applicant has a right to view the Evidence of Coverage prior to enrollment.

Individuals with special health care needs should read those sections that apply to them.

Your Plan Benefits may differ from the coverage outlined in this brochure. For more details about the benefits of Your Plan, please see the Health Plan Benefit and Coverage Matrix insert on the following page as well as the Schedule of Benefits, the Schedule of Exclusions and Limitations, and any riders, endorsements or addenda attached to this Evidence of Coverage.

Please read the following information so you will understand how this program works and how to receive benefits

Health Plan Benefits and Coverage Matrix

This matrix is intended to help you compare coverage and benefits and is a summary only. **THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM, as well as the Schedule of Benefits, the Schedule of Exclusions and Limitations, and any riders, endorsements or addenda attached to this Evidence of Coverage SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

Category	Copayments and Limitations
Deductibles	Deductibles, if any, are listed on the Schedule of Benefits
Lifetime Maximum	Lifetime Maximums, if any, are listed on the Schedule of Benefits
Annual Maximum	Annual Maximums, if any, are listed on the Schedule of Benefits
Professional Services	All Copayments are listed on the Schedule of Benefits
Outpatient Services	None – This Plan covers only dental services
Hospitalization Services	None – This Plan covers only dental services
Emergency Health Coverage	In case of a Dental Emergency, the Plan covers necessary diagnostic and therapeutic dental procedures for immediate treatment administered by an In-Network Dentist or an Out-of-Network Dentist. Your Copayment is based on services received, up to a maximum of $100 for each emergency visit.
Ambulance Services	None – This Plan covers only dental services
Prescription Drug Coverage	None – This Plan covers only dental services
Durable Medical Equipment	None – This Plan covers only dental services
Mental Health Services	None – This Plan covers only dental services
Residential treatment	None – This Plan covers only dental services
Chemical Dependency Services	None – This Plan covers only dental services
Home Health Services	None – This Plan covers only dental services
Custodial Care and skilled nursing facilities	None – This Plan covers only dental services

For questions You may have related to this benefit matrix, You may contact the Department of Managed Health Care Help Center at 1-888-466-2219 OR contact a customer service representative of the Plan at 1-800-937-6432.

EVIDENCE OF COVERAGE

INTRODUCTION

This Evidence 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 Evidence of Coverage and the Group Contract, the Group Contract will rule. This Evidence of Coverage is not a summary plan description under the Employee Retirement Income Security Act (ERISA).

If You have questions about Your coverage or benefits, or for questions regarding general information, Concordia Plus Dentist availability or Benefit information please call our Customer Service Department toll-free at:

800-937-6432

You may also log on to our website at:

www.unitedconcordia.com

Claim forms should be sent to:

United Concordia Companies, Inc.
PO Box 10194
Van Nuys, CA 91410

TABLE OF CONTENTS

Attached:

SCHEDULE OF BENEFITS
SCHEDULE OF EXCLUSIONS AND LIMITATIONS

DEFINITIONS

Certain terms used throughout this Evidence of Coverage 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.

Combined Evidence of Coverage and Disclosure Form ("Evidence of Coverage") -This document, and its riders, schedules, addenda and/or endorsements, if any, which describe the coverage purchased from the Company by the Contractholder.

Company - United Concordia Dental Plans of California, 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 charges set forth in the Schedule of Benefits that the Member is responsible to pay the treating Dentist.

Cosmetic - Services or procedures that are primarily intended 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 Evidence of Coverage.

Dental Emergency - Services that diagnose and treat a dental condition, which is manifested by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate dental attention could reasonably be expected to result in any of the following: (a) Placing the health of the individual in serious jeopardy, (b) Serious impairment of the bodily functions, or (c) Serious dysfunction of any bodily organ or part.

Dentally Necessary- A dental service or procedure determined by a Dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the Dentist and the prevailing standards of care in the professional community.

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 Subscriber.

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

1. The Subscriber's Spouse or domestic partner as defined under Section 297 of the California Family Code; and
2. A relative of the Subscriber or other individual who resides with the Subscriber and for whom the Subscriber can claim a dependent tax deduction according to the rules of the Internal Revenue Service; and
3. Any natural child, stepchild, adopted child or child placed with the Subscriber or the Subscriber's Spouse or domestic partner by order of a court or administrative agency:

(a) until the end of the month that the child reaches age twenty-six (26); or
(b) to any age if the child is and continues to be both incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition and chiefly dependent upon the Subscriber for maintenance and support.

Effective Date - The date on which the Group Contract begins or coverage of enrolled Member(s) 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 experimental or investigative treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Company determines is not the currently acceptable standard of care.

Family Contract - A Group Contract that covers the Contractholder's Subscribers 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 no less than thirty-one (31) days after Premium payment is due under the Group Contract, in which the Contractholder may make such payment and during which the protection of the Group Contract continues, subject to the payment of Premium by the end of the Grace Period.

Group Contract - The agreement between the Company and the Contractholder, under which the Subscriber 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 that restricts a Covered Service set forth in the Schedule of Exclusions and Limitations.

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

Member(s) - Enrolled Subscribers 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 Evidence of Coverage, costs of services that exceed the Group Contract's Limitations, Annual Maximum or Lifetime Maximums, or for services that are Exclusions. The Subscriber 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 Subscriber 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 Evidence of Coverage 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 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.

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

Specialty Care Dentist - A specialized Dentist who is qualified 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 Subscriber's partner by marriage or by any union between two adults that is recognized by law in California.

Subscriber - An individual who, because of his/her status with the Contracholder, has enrolled him/herself and/or his/her eligible Dependents for dental coverage and for whom Premiums are paid. Also referred to as "You" or "Your" or "Yourself".

Terminated Provider - A Dentist that formerly delivered services under contract that is no longer associated with the Plan and has become an Out-of-Network Dentist.

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 Subscriber, 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 Subscribers 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 all applicable eligibility requirements.

Coverage for Members enrolling after the Group Contract Effective Date will begin on the first day of the month following 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 procedure cannot be undone or reversed. 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 the Subscriber may add or remove Dependents. These life change events include:

- birth of a child;
- adoption of a child;
- court order of placement or custody of a child;
- loss of other coverage;
- marriage or other lawful union between two adults;

If You enrolled through Your Group, to enroll a new Dependent 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 Subscriber 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 first day of the month following the date specified in the enrollment information provided to Us, as long as the Premium is paid.

Newly born children of a Member will be considered enrolled from the moment of birth. Adoptive children will be considered enrolled from the date of adoption or placement, except for those adopted or placed within thirty-one (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 thirty-one (31) day period, the child's enrollment information must be provided to Us and the required Premium must be paid within the thirty-one (31) day period.

For an enrolled Dependent child who has a physically or mentally disabling injury, illness, or condition, evidence of his/her reliance on You for maintenance and support due to his/her condition must be supplied to Us within sixty (60) days of the date of receipt of the Company's notification that the dependent child's coverage will terminate upon attainment of the limiting age unless the Member submits proof of a physically or mentally disabling injury, illness, or condition, or physical handicap. 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 after a two year waiting period once the initial evidence is provided.

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 when otherwise permitted by applicable law or regulation or specified in any applicable Late Entrant Rider to the Evidence 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 unless otherwise permitted by applicable law or regulation intended to implement the federal Affordable Care Act. 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.

Prepayment Fees

Prepayment Fees are the periodic payment of Premium Your Group must pay for coverage under this Plan. Your Group is responsible to remit the proper amount of Premium. You may consult Your Group for more details. Prepayment fee is not the same as a Copayment. Copayments are Your responsibility.

Subscribers should contact the Contractholder for information regarding any sums to be withheld from his/her salary or any amounts the Subscriber pays Your Group for this Plan.

HOW THE DENTAL PLAN WORKS

Facilities

The Primary Dental Office is the principal facility under this Plan. To determine Your Primary Dental Office, refer to the Choice of Providers section of this Evidence of Coverage.

Choice of Providers

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 Evidence of Coverage or on Your ID card, or refer to the Primary Dentist list in Your enrollment materials.

Once enrolled, You will receive an ID Card or other notification indicating Your contract ID number, plan number and Group number, 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.

WARNING: You must go to Your Primary Dental Office or obtain a referral from Your Primary Dental Office to an In-Network Dentist to have coverage under this Plan. Services performed by an Out-of-Network Dentist will not be covered. The only exceptions are if You have a Dental Emergency or if a Primary Dentist or Specialty Care Dentist is not available in Your area. See the section entitled Dental Emergency for details on this situation.

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 Evidence of Coverage or visit Our website. You will be informed of the effective date of Your 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.

Provider Reimbursement

We reimburse Your Primary Dental Office on a prepaid basis for Members enrolled in their offices. Primary Dental Offices may also receive additional payment for Covered Services as services are provided under the Plan.

We reimburse Specialty Care Dentists a Maximum Allowable Charge for Covered Services eligible for referral. No further incentives or financial bonuses are provided to In-Network Dentists. If You who wish to obtain further information on provider reimbursement You may contact the Customer Service toll-free number in the Introduction section of this Evidence of Coverage.

Continuity of Care

Current Members may have the right to the benefit of completion of care with their Terminated Provider for certain specified dental conditions. Please call the Plan at the toll-free number in the Introduction section of this Evidence of Coverage to see if you may be eligible for this benefit. You may request a copy of the Plan's Continuity of Care Policy. You must make a specific request to continue under the care of Your Terminated Provider. We are not required to continue Your care with that Dentist if You are not eligible under our policy or if We cannot reach agreement with Your Terminated Provider on the terms regarding Your care in accordance with California law.

New Members may have the right to the qualified benefit of completion of care with their Non-participating Provider for certain specified dental conditions. Please call the Plan at the toll-free number in the Introduction section of this Evidence of Coverage to see if You may be eligible for this benefit. You may request a copy of the Plan's Continuity of Care Policy. You must make a specific request to continue under the care of Your current provider. We are not required to continue Your care with that provider if You are not eligible under our policy or if We cannot reach agreement with Your provider on the terms regarding Your care in accordance with California law. This policy does not apply to new Members of an individual subscriber contract.

If You are undergoing treatment when an In-Network Dentist becomes a Terminated Provider, You will be held harmless for Covered Services, except for Copayments, until such treatment from the Terminated Provider is completed, unless We make reasonable and medically appropriate provision for an In-Network Dentist to take over Your treatment.

We will provide written notice to You within thirty-one (31) days of the termination or breach of contract by an In-Network Dentist or the inability of an In-Network Dentist to perform such that there may be a material and adverse impact and thereby harm to Members receiving Covered Services under the Plan.

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. With the exception of Dental Emergencies or if a Primary Dentist or Specialty Care Dentist is not available in Your area, all benefits must be provided by an In-Network Dentist. 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 can 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. Referral is limited to endodontic, orthodontic, periodontic, oral surgery, and pedodontic Specialty Care Dentists.

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 Evidence of Coverage or log onto *My Dental Benefits* at *www.unitedconcordia.com*.

There are only two (2) situations when You may receive a benefit for Covered Services performed by an Out-of-Network Dentist: Dental Emergencies; and when an In-Network Dentist is not available in Your area.

Dental Emergencies

If You have a Dental Emergency, You should contact Your Primary Dental Office. If You are unable to contact Your Primary Dental Office, You should contact the Customer Service number on the front of this Evidence of Coverage to arrange treatment for Your Dental Emergency or go to a conveniently located general Dentist. A Dental Emergency does not require preauthorization. Ask the dental office to call Customer Service to verify coverage. Obtain an itemized bill from the dental office to submit to the address in the Reimbursement Provisions section below. The Plan will cover certain diagnostic and therapeutic procedures in accordance with the Schedule of Benefits. Your out-of-pocket cost will be limited to any applicable Copayment on the Schedule of Benefits. You must return to Your Primary Dental Office for any necessary follow-up care.

Out-of-Network Care and Reimbursement Provisions

In the event that a Primary Dental Office or Specialty Care Dentist is not available in Your area, We may authorize treatment by an Out-of-Network Dentist. You are liable for only the applicable Copayment, as indicated in Your Schedule of Benefits. If You have paid the Out-of-Network Dentist, the Plan will reimburse You the difference between the charge and the Copayment as listed on Your Schedule of Benefits. You should submit a claim form to United Concordia Companies, Inc. at the address on the first page of this Evidence of Coverage within sixty (60) days of obtaining the authorization for treatment or within sixty (60) days for a Dental Emergency treated by an Out-of-Network Dentist. Most treating Dentists will provide and complete the claim form for You. However, if You need to obtain a claim form, You may do so on Our website.

If We do not authorize Your treatment from an Out-of-Network Dentist and We fail to pay that Out-of-Network Dentist, You may have to pay the Out-of-Network Dentist for the entire cost of the services. Additional clarification is provided in the section entitled Dental Emergencies and Out-of-Network Care.

Liability of Members in the Event of Non-payment

All contracts between Us and the Primary Dentist or Specialty Care Dentist state that under no circumstances shall You be liable to any Dentist for any sum owed by the Plan to the Dentist. In any instance where We fail or refuse to pay the Dentist, such dispute is solely between the Dentist and Us, and You are not liable for any monies We fail or refuse to pay.

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. 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

Copayments

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.

IMPORTANT: *If You opt to receive dental services that are not Covered Services under this Plan, an In-Network Dentist may charge You his or her usual and customary rate for those services. Prior to providing a Member with dental services that are not a Covered Service, the Dentist should provide to the Member a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about dental coverage options, You may call our Customer Service Department at the toll-free number in the Introduction section of this Evidence of Coverage or Your insurance broker. To fully understand Your coverage, You may wish to carefully review this Evidence of Coverage.*

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 Copayment 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 Exclusions and Limitations attached to this Evidence of Coverage. Services not listed on the Schedule of Benefits, Exclusions, or those beyond stated Limitations are not covered and are Your responsibility.

Other Charges for Alternative Treatment

All diagnosis and treatment planning is provided by Your Primary Dental Office. Occasionally, You and Your Primary Dental Office may consider alternative treatment plans that are not Covered Services. In those instances, You are responsible for the additional cost for the alternative treatment. The cost of the alternative treatment will be calculated on the difference between the provider's usual fee for the alternative treatment and the usual fee for the Covered Service plus the Copayment of the Covered Service.

Your Primary Dental Office is responsible to discuss the alternative treatment and its costs with You. Your Primary Dental Office should also seek Your authorization for the alternative treatment, in writing, before the services are performed.

Payment of Benefits

We will pay for 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 Dentist state that under no circumstances will the Member be liable to any Dentists for any sum owed by Us to the Dentist. In any instance where 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.

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 the Primary Dental Benefit Plan and determine its benefits before those of the other plan and without considering the other plan's benefits. The other plan will be the Secondary Dental Benefit Plan and determine its benefits after the Primary Dental Benefit Plan. The Secondary Dental Benefit Plan's benefits may be reduced because of the Primary Dental Benefit Plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses to prevent duplicate payments and overpayments. Upon determination of primary or secondary liability, This Plan will determine payment. If This Plan is the Secondary Dental Benefit Plan, payment during the Claim Determination Period will not exceed the total of the Allowable amount.

1. When used in this Coordination of Benefits section, the following words and phrases have the definitions below:

   A) **Allowable Amount** is the Plan's allowance for items of expense, when the care is covered at least in part by one or more Plans covering the Member for whom the claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service provided shall be deemed to be both an Allowable Amount and a benefit paid.
   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: Medicare, 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 Dental Benefit Plan** is the plan which provides primary dental coverage and 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 Dental Benefit Plan** is the plan which provides secondary dental coverage and determines its benefits after those of the other plan (Primary Dental Benefit Plan). Benefits may be reduced because of the other plan's (Primary Dental Benefit Plan) benefits.
   F) **This 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.
   G) **Plan** means either the Primary Dental Benefit Plan or the Secondary Dental Benefit Plan.

2. The reasonable cash 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.

   A) As the Primary Dental Benefit Plan, the Company will pay the maximum amount required by Your Group Policy when coordinating its benefits with a Secondary Dental Benefit Plan.
   B) As the Secondary Dental Benefit Plan, the Company will pay the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the Member's total out-of-pocket cost payable under the Primary Dental Benefit Plan for benefits covered under the Secondary Dental Benefit Plan.

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

A) If the Other Dental Plan does not have a provision similar to this one, then that Plan will be primary and This Plan's Coordination of Benefits rules apply.
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 or other rule, and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent or other rule 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 sixty-five (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. A retirement plan refers to a plan covering a retired employee or Dependent of an employee. An active plan refers to a plan that covers a person as an employee or Dependent of an employee. When two retirement plans are involved, the one in effect for the longest time is primary. When plan is under a retirement plan and the other plan is for a laid off employee, the plan of the laid off employee is primary. If another contract does not have this rule which results in each plan determine benefits of another, then this rule will be ignored.
F) The plan covering an individual as a Cal-COBRA continuee will be secondary to a plan covering that individual as a Subscriber, or a Member. If another plan does not have this rule which results in each plan determine benefits of another, then this rule will be ignored.

G) If none of these rules apply, then the contract which has continuously covered the Member for whom the claim was made for a longer period of time will be primary.

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 benefits provided in the form of 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.

Review of a Benefit Determination

If You are not satisfied with a benefit determination or payment, please contact Our Customer Service Department at the toll-free telephone number in the Introduction section of this Evidence of Coverage or on Your ID card. If, after speaking with a Customer Service representative, You are still dissatisfied, refer to the following Second Opinion and Grievance Resolution Procedure for further steps You can take regarding Your claim.

Second Opinion

You or Your In-Network Dentist may request a second opinion. The request for second opinion may be made by calling or writing to Customer Service at the address or telephone number shown below under "Grievance Resolution". Reasons for a second opinion include, but are not limited to:

1. If You have questions on the reasonableness or necessity of recommended surgical procedures;
2. If You have questions on a diagnosis or plan of care for a condition that threatens life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition;
3. If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and You request an additional diagnosis;
4. If the treatment plan in progress is not improving Your dental condition within an appropriate period of time given the diagnosis and plan of care, and You request a second opinion regarding the diagnosis or continuance of the treatment; or
5. If You have attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

Authorization or denial of a second opinion request will be made in an expeditious manner. When Your condition is such that You face an imminent and serious threat to Your health, including, but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness that would be detrimental to Your ability to regain maximum function, the decision for authorization or denial for second opinion will be rendered in a timely fashion appropriate for the nature of the condition, not to exceed seventy-two (72) hours from the receipt of the request, whenever possible. These written guidelines regarding timelines for responding to second opinion requests are available to You upon request.

The cost of an authorized second opinion will be Our responsibility, minus any applicable Copayment that You must pay at the time of service. Non-authorized second opinions are Your sole financial responsibility.

An authorized second opinion will be provided by an appropriately qualified In-Network Dentist of Your choice. If no other In-Network Dentist is reasonably available who meets this standard, We will authorize an out-of-network second opinion. Second opinions are not covered with out-of-network providers without Our prior approval.

If We deny a request for second opinion, You may file a grievance following the Grievance Resolution Procedure.

GRIEVANCE RESOLUTION PROCEDURE

Any Member not satisfied with any aspect of the Plan may file a written complaint/grievance. While We

prefer the complaint/grievance to be filed in writing, complaints/grievances may be submitted verbally with the assistance of a Plan representative. Assistance with filing a complaint/grievance is provided, as necessary, at each location where complaints/grievances may be filed. You, or a person acting on Your behalf, must file a complaint/grievance within one-hundred eighty (180) days following the incident or action that is the subject of Your dissatisfaction. The complaint/grievance should contain sufficient detail to identify the nature of the problem.

Your written complaint/grievance must be submitted to the Customer Services Department at the address or website on the first page of this Evidence of Coverage, or you may call Customer Service for assistance at the toll-free number in the Introduction section of this Evidence of Coverage or on Your ID card.

You will not be subject to discrimination, disenrollment, or otherwise penalized for filing a complaint/grievance.

Complaint/Grievance forms and a description of the complaint/grievance procedure are available directly from Us, on Our website and at each contracted provider's facility, and are provided promptly upon request.

Receipt of your concern will be acknowledged within five (5) days. After receipt, all parties involved will be contacted and any pertinent facts, dental records, or other supportive materials will be collected. **A copy of your grievance will be forwarded to the dental office(s) which is/are the subject of the grievance.**

Complaints/grievances will be resolved within thirty (30) days. A notice of the disposition for the complaint/grievance will be sent to the member within thirty (30) days from the receipt of the complaint/grievance.

If You have received a decision from Us on Your complaint/grievance, or if You have been involved in the complaint/grievance process for more than thirty (30) days, You may file a complaint/grievance with the Department of Managed Health Care (DMHC). You may also file a complaint/grievance with the DMHC any time the DMHC determines Your case involves imminent and serious threat to Your health, including but not limited to severe pain, potential loss of life, limb, or major bodily function, or in any case where the DMHC determines that an earlier review is warranted.

Because of regulations concerning the confidentiality of patient medical records, any resolution to complaint/grievance will be forwarded to the Dental Office and Member only. All such replies will be made in writing and will be held in the strictest confidence.

If You are not proficient in English, are hearing impaired, are visually impaired, or are otherwise impaired such that access to Our complaint/grievance system is potentially hampered, We provide assistance as necessary.

United Concordia's complaint/grievance system addresses the linguistic and cultural needs of its members as well as the needs of members with disabilities, to ensure that all members have access to and can fully participate in the complaint/grievance system, by the following means:

1. Translations of complaint/grievance procedures, forms, and plan responses to complaints/grievances, as needed,
2. Access to telephone interpreters,
3. Access to telephone relay systems and other devices that aid disabled individuals to communicate,
4. Other individualized assistance to meet the Member's specific needs.

You can access the above referenced services by contacting Customer Service at the telephone number listed on the first page of this Evidence of Coverage or on Your ID card.

If Your complaint/grievance involves an imminent or serious threat to Your health, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, We will conduct an expedited

review of the complaint/grievance. Upon receiving notice of an expedited review case, We will immediately inform You of Your rights and the method to notify the DMHC of the complaint/grievance. We also will notify You of the disposition or pending status of the expedited complaint/grievance no later than three (3) days from receipt of the complaint/grievance.

Due to regulatory constraints on the timeline for complaint/grievance resolution, a complaint/grievance determination **may not** be appealed to Us.

The California Department of Managed Health Care is responsible for regulating health care service plans. If You have a grievance against Your health plan, You should first telephone Your health plan at **1-866-357-3304** and use Your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to You. If You need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Your health plan, or a grievance that has remained unresolved for more than 30 days, You may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If You are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

RENEWAL PROVISIONS

Upon completion of the original term, this Group Contract shall automatically be renewed on an annual basis as provided for in the Group Contract. The Company will supply You with a copy of the Group Contract upon request.

RIGHT OF CANCELLATION AND RESTRICTIONS ON RENEWAL

This Plan may be cancelled or terminated at any time based upon the Termination of Benefits Section below.

TERMINATION OF BENEFITS

A Member's coverage will end at 12:00 AM PST:

- on the date You lose 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 Evidence of Coverage; or
- on the postmark date of the notice We provide to You regarding a final disposition of a fraud conviction for the Subscriber or his/her Dependents; or
- on the date the Subscriber's residence changes to an area outside the State of California. Coverage shall continue for Dependents who reside in California with a non-custodial parent.

On the date the Subscriber's coverage ends or the Subscriber is no longer eligible to enroll his/her Dependents, Dependent coverage will end. If the Group Contract is cancelled, Subscriber and Dependent coverage will end on the Group Contract Termination Date.

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.

A Member who alleges that this Evidence of Coverage was not renewed or terminated due to a family Member's or Subscriber's health status may request a review for cancellation from the Director of the Department of Managed Health Care.

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 procedure cannot be undone or reversed. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Member's Termination Date. This extension does not apply if the Group Contract terminates for failure to pay Premium.

CONTINUATION COVERAGE

Federal or state law may require that certain employers offer continuation coverage to Members for a period of time upon the Subscriber's reduction of work hours or termination of employment for any reason other than gross misconduct. 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 from 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.

GENERAL PROVISIONS

This Evidence of Coverage 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 Evidence of Coverage shall not affect the validity, legality and enforceability of the remaining sections.

With the approval of the Department of Managed Health Care (or its successors), the Company may assign this Evidence of Coverage, and its rights and obligations hereunder to any entity under common control with the Company.

This Evidence of Coverage 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 California.

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 Evidence of Coverage may be amended, changed or modified only in writing and thereafter attached hereto as part of this Evidence of Coverage.

Suggestions and Comments

We welcome Your suggestions and comments to improve the service for this Plan. You may submit questions and comments to Our Public Policy Committee. The Public Policy Committee establishes and reviews the Plan's public policy. The Committee consists of representatives of at least 51% of covered Members under this Plan. If You wish to be considered for selection to the Committee, submit Your qualifications in writing to the address on the front of this Evidence of Coverage. The Plan reviews its Committee membership annually. The Plan will notify You of its selection decisions after that annual review.

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®

Concordia Plus Schedule of Benefits

Plan CA 01

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.
- In-Network Dentists will charge an additional $125 for the use of precious (high noble) or semi precious (noble) metal.
- 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 $
	CLINICAL ORAL EVALUATIONS	
D0120	Periodic Oral Evaluation - Established Patient	0
D0140	Limited Oral Evaluation - Problem Focused	0
D0145	Oral Evaluation For A Patient Under 3 Years Of Age And Counseling With Primary Caregiver	0
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	0
D0170	Re-Evaluation-Limited, Problem Focused (Established Patient; Not Post-Operative Visit)	0
D0171	Re-Evaluation - Post-Operative Office Visit	0
D0180	Comprehensive Periodontal Evaluation	0
	RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)	
D0210	Intraoral - Complete Series Of Radiographic Images	0
D0220	Intraoral- Periapical First Radiographic Image	0
D0230	Intraoral- Periapical Each Additional Radiographic Image	0
D0240	Intraoral - Occlusal Radiographic Image	0
D0250	Extra-oral - 2D Projection Radiographic Image Created Using A Stationary Radiation Source, And Detector	0
D0251	Extra-oral Posterior Dental Radiographic Image	0
D0270	Bitewing - Single Radiographic Image	0
D0272	Bitewings - Two Radiographic Images	0
D0273	Bitewings - Three Radiographic Images	0
D0274	Bitewings - Four Radiographic Images	0
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	0
D0330	Panoramic Radiographic Image	0
D0340	2D Cephalometric Radiographic Image - Acquisition, Measurement And Analysis	0

ADA Code	ADA Description	Member Pays $
	RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)	
D0350	2D Oral/Facial Photographic Image Obtained Intra-Orally Or Extra-Orally	0
	TESTS AND EXAMINATIONS	
D0415	Collection Of Microorganisms For Culture And Sensitivity	0
D0416	Viral Culture	0
D0417	Collection And Preparation Of Saliva Sample For Laboratory Diagnostic Testing	0
D0418	Analysis Of Saliva Sample	0
D0422	Collection and Preparation Of Genetic Sample Material For Laboratory Analysis And Report	0
D0423	Genetic Test for Susceptibility To Diseases - Specimen Analysis	0
D0425	Caries Susceptibility Tests	0
D0431	Adjunctive Pre-Diagnostic Test That Aids In Detection Of Mucosal Abnormalities Including Premalignant And Malignant Lesions, Not To Include Cytology Or Biopsy Procedures	0
D0460	Pulp Vitality Tests	0
D0470	Diagnostic Casts	0
	ORAL PATHOLOGY LABORATORY	
D0472	Accession Of Tissue, Gross Examination, Preparation And Transmission Of Written Report	0
D0473	Accession Of Tissue, Gross And Microscopic Examination, Preparation And Transmission Of Written Report	0
D0474	Accession Of Tissue, Gross And Microscopic Examination, Including Assessment Of Surgical Margins For Presence Of Disease, Preparation And Transmission Of Written Report	0
D0502	Other Oral Pathology Procedures, By Report	0
D0601	Caries Risk Assessment And Documentation, With A Finding Of Low Risk	0

ADA Code	ADA Description	Member Pays $
	ORAL PATHOLOGY LABORATORY	
D0602	Caries Risk Assessment And Documentation, With A Finding Of Moderate Risk	0
D0603	Caries Risk Assessment And Documentation, With A Finding Of High Risk	0
	DENTAL PROPHYLAXIS	
D1110	Prophylaxis, Adult	0
D1120	Prophylaxis, Child	0
	TOPICAL FLUORIDE TREATMENT (office procedure)	
D1206	Topical Application Of Fluoride Varnish	0
D1208	Topical Application Of Flouride - Excluding Varnish	0
	OTHER PREVENTIVE SERVICES	
D1310	Nutritional Counseling For The Control Of Dental Disease	0
D1320	Tobacco Counseling For The Control And Prevention Of Oral Disease	0
D1330	Oral Hygiene Instruction	0
D1351	Sealant - Per Tooth	0
D1353	Sealant Repair - Per Tooth	0
D1354	Interim Caries Arresting Medicament Application	15
	SPACE MAINTENANCE (passive appliances)	
D1510	Space Maintainer - Fixed, Unilateral (Tooth Numbers Or Tooth Area Required)	0
D1515	Space Maintainer - Fixed, Bilateral	0
D1520	Space Maintainer - Removable, Unilateral	0
D1525	Space Maintainer - Removable, Bilateral	0
D1550	Re-Cement Or Re-Bond Space Maintainer	0
D1555	Removal Of Fixed Space Maintainer	0
D1575	Distal shoe space maintainers - fixed - unilateral	0
	AMALGAM RESTORATIONS (including polishing)	
D2140	Amalgam - One Surface, Primary Or Permanent	0
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0
	RESIN-BASED COMPOSITE RESTORATIONS - DIRECT	
D2330	Resin-Based Composite - One Surface, Anterior	0
D2331	Resin-Based Composite - Two Surfaces, Anterior	0
D2332	Resin-Based Composite - Three Surfaces, Anterior	0
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle (Anterior)	0
D2390	Resin-Based Composite Crown, Anterior	0
D2391	Resin-Based Composite - One Surface, Posterior	85
D2392	Resin-Based Composite - Two Surfaces, Posterior	109
D2393	Resin-Based Composite - Three Surfaces, Posterior	133
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	140
	INLAY/ONLAY RESTORATIONS	
D2510	Inlay - Metallic - One Surface	0 ◆
D2520	Inlay - Metallic - Two Surfaces	0 ◆
D2530	Inlay - Metallic - Three Or More Surfaces	0 ◆
D2542	Onlay - Metallic-Two Surfaces	0 ◆
D2543	Onlay - Metallic - Three Surfaces	0 ◆
D2544	Onlay - Metallic - Four Or More Surfaces	0 ◆
	CROWNS - SINGLE RESTORATIONS ONLY	
D2710	Crown-Resin-Based Composite (Indirect)	0
D2712	Crown - 3/4 Resin-Based Composite (Indirect)	0
D2720	Crown, Resin With High Noble Metal	0 ◆
D2721	Crown, Resin With Predominantly Base Metal	0
D2722	Crown, Resin With Noble Metal	0 ◆
D2740	Crown, Porcelain/Ceramic Substrate	0
D2750	Crown, Porcelain Fused To High Noble Metal	0 ◆
D2751	Crown-Porcelain Fused To Predominantly Base Metal	0
D2752	Crown, Porcelain Fused To Noble Metal	0 ◆
D2780	Crown - 3/4 Cast High Noble Metal	0 ◆
D2781	Crown - 3/4 Cast Predominantly Base Metal	0
D2782	Crown - 3/4 Cast Noble Metal	0 ◆
D2783	Crown - 3/4 Porcelain/Ceramic	0
D2790	Crown, Full Cast High Noble Metal	0 ◆
D2791	Crown - Full Cast Predominantly Base Metal	0
D2792	Crown, Full Cast Noble Metal	0 ◆
D2794	Crown-Titanium	0
D2799	Provisional Crown - Further Treatment Or Completion Of Diagnosis Necessary Prior To Final Impression	0
	OTHER RESTORATIVE SERVICES	
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	0
D2915	Re-Cement Or Rebond Indirectly Fabricated Or Prefabricated Post And Core	0
D2920	Re-Cement Or Re-Bond Crown	0
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	0
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	0
D2932	Prefabricated Resin Crown	0
D2933	Prefabricated Stainless Steel Crown With Resin Window	0
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	0
D2940	Protective Restoration	0
D2949	Restorative Foundation For An Indirect Restoration	0
D2950	Core Buildup Including Any Pins When Required	0
D2951	Pin Retention - Per Tooth, In Addition To Restoration	0
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	0
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	10
D2954	Prefabricated Post And Core In Addition To Crown	0
D2955	Post Removal	0
D2957	Each Additional Prefabricated Post - Same Tooth	10

ADA Code	ADA Description	Member Pays $
	OTHER RESTORATIVE SERVICES	
D2971	Additional Procedures To Construct New Crown Under Existing Partial Denture Framework	25
D2980	Crown Repair Necessitated By Restorative Material Failure	0
D2981	Inlay Repair Necessitated By Restorative Material Failure	0
D2982	Onlay Repair Necessitated By Restorative Material Failure	0
	PULP CAPPING	
D3110	Pulp Cap - Direct (Excluding Final Restoration)	0
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	0
	PULPOTOMY	
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	0
D3221	Pulpal Debridement, Primary And Permanent Teeth	0
D3222	Partial Pulpotomy For Apexogenesis-Permanent Tooth With Incomplete Root Development	0
	ENDODONTIC THERAPY ON PRIMARY TEETH	
D3230	Pulpal Therapy (Resorbable Filling)-Anterior, Primary Tooth (Excluding Final Restoration)	0
D3240	Pulpal Therapy (Resorbable Filling)-Posterior, Primary Tooth (Excluding Final Restoration)	0
	ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	0
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)	0
D3330	Endodontic Therapy, Molar (Excluding Final Restoration)	0
	ENDODONTIC RETREATMENT	
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	0
D3347	Retreatment Or Previous Root Canal Therapy - Bicuspid	0
D3348	Retreatment Of Previous Root Canal Therapy - Molar	0
	APEXIFICATION/RECALCIFICATION PROCEDURES	
D3351	Apexification/Recalcification - Initial Visit (Apical Closure / Calcific Repair Of Perforations, Root Resorption, Etc.)	0
D3352	Apexification/Recalcification - Interim Medication Replacement (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Pulpal Space Disinfection, Etc.)	0
D3353	Apexification/Recalcification-Final Visit (Includes Completed Root Canal Therapy-Apical Closure/Calcific Repair Of Perforations, Root Resorption, Etc.)	0
D3355	Pulpal Regeneration - Initial Visit	0
D3356	Pulpal Regeneration - Interim Medication Replacement	0
D3357	Pulpal Regeneration - Completion Of Treatment	0
	APICOECTOMY/PERIRADICULAR SERVICES	
D3410	Apicoectomy - Anterior	0
D3421	Apicoectomy - Bicuspid (First Root)	0

ADA Code	ADA Description	Member Pays $
	APICOECTOMY/PERIRADICULAR SERVICES	
D3425	Apicoectomy - Molar (First Root)	0
D3426	Apicoectomy (Each Additional Root)	0
D3427	Periradicular Surgery Without Apicoectomy	0
D3430	Retrograde Filling - Per Root	0
D3450	Root Amputation - Per Root	0
	OTHER ENDODONTIC PROCEDURES	
D3910	Surgical Procedure For Isolation Of Tooth With Rubber Dam	0
D3920	Hemisection (Including Any Root Removal) Not Including Root Canal Therapy	0
D3950	Canal Preparation And Fitting Of Preformed Dowel Or Post	0
	SURGICAL SERVICES (including usual postoperative care)	
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	0
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	0
D4212	Gingivectomy Or Gingivoplasty To Allow Access For Restorative Procedure, Per Tooth	0
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	0
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	0
D4245	Apically Positioned Flap	0
D4249	Clinical Crown Lengthening-Hard Tissue	0
D4260	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	0
D4261	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	0
D4263	Bone Replacement Graft - Retained Natural Tooth - First Site In Quadrant	120
D4264	Bone Replacement Graft - Retained Natural Tooth - Each Additional Site In Quadrant	92
D4274	Mesial/Distal Wedge Procedure, Single Tooth (When Not Performed In Conjunction With Surgical Procedures In The Same Anatomical Area)	0
	NON-SURGICAL PERIODONTAL SERVICES	
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	0
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	0
D4346	Scaling In Presence Of Generalized Moderate Or Severe Gingival Inflammation - Full Mouth, After Oral Evaluation	0
D4355	Full Mouth Debridement To Enable Comprehensive Evaluation And Diagnosis	0
D4381	Localized Delivery Of Antimicrobial Agents Via Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth	43
	OTHER PERIODONTAL SERVICES	
D4910	Periodontal Maintenance	0
D4920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist Or Their Staff)	0

ADA Code	ADA Description	Member Pays $	
	OTHER PERIODONTAL SERVICES		
D4921	Gingival Irrigation - Per Quadrant	25	
	COMPLETE DENTURES (including routine post delivery care)		
D5110	Complete Denture - Maxillary	0	
D5120	Complete Denture - Mandibular	0	
D5130	Immediate Denture - Maxillary	0	
D5140	Immediate Denture - Mandibular	0	
	PARTIAL DENTURES (including routine post-delivery care)		
D5211	Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth)	0	
D5212	Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth)	0	
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests And Teeth)	0	
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rest And Teeth)	0	
D5221	Immediate Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests and Teeth)	0	
D5222	Immediate Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests and Teeth)	0	
D5223	Immediate Maxillary Partial Denture - Case Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests And Teeth)	0	
D5224	Immediate Mandibular Partial Denture - Case Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests And Teeth)	0	
D5225	Maxillary Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	0	
D5226	Mandibular Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	0	
D5281	Removable Unilateral Partial Denture-One Piece Cast Metal (Including Clasps	0	
	ADJUSTMENTS TO DENTURES		
D5410	Adjust Complete Denture - Maxillary	0	
D5411	Adjust Complete Denture - Mandibular	0	
D5421	Adjust Partial Denture - Maxillary	0	
D5422	Adjust Partial Denture - Mandibular	0	
	REPAIRS TO COMPLETE DENTURES		
D5510	Repair Broken Complete Denture Base	0	
D5520	Replace Missing Or Broken Teeth-Complete Denture (Each Tooth)	0	
	REPAIRS TO PARTIAL DENTURES		
D5610	Repair Resin Denture Base	0	
D5620	Repair Cast Framework	0	
D5630	Repair Or Replace Broken Clasp - Per Tooth	0	
D5640	Replace Broken Teeth-Per Tooth	0	
D5650	Add Tooth To Existing Partial Denture	0	
D5660	Add Clasp To Existing Partial Denture - Per Tooth	0	
D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)	0	

ADA Code	ADA Description	Member Pays $	
	REPAIRS TO PARTIAL DENTURES		
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	0	
	DENTURE REBASE PROCEDURES		
D5710	Rebase Complete Maxillary Denture	0	
D5711	Rebase Complete Mandibular Denture	0	
D5720	Rebase Maxillary Partial Denture	0	
D5721	Rebase Mandibular Partial Denture	0	
	DENTURE RELINE PROCEDURES		
D5730	Reline Complete Maxillary Denture (Chairside)	0	
D5731	Reline Complete Mandibular Denture (Chairside)	0	
D5740	Reline Maxillary Partial Denture (Chairside)	0	
D5741	Reline Mandibular Partial Denture (Chairside)	0	
D5750	Reline Complete Maxillary Denture (Laboratory)	0	
D5751	Reline Complete Mandibular Denture (Laboratory)	0	
D5760	Reline Maxillary Partial Denture (Laboratory)	0	
D5761	Reline Mandibular Partial Denture (Laboratory)	0	
D5810	Interim Complete Denture (Maxillary)	0	
D5811	Interim Complete Denture (Mandibular)	0	
D5820	Interim Partial Denture (Maxillary)	0	
D5821	Interim Partial Denture (Mandibular)	0	
	OTHER REMOVABLE PROSTHETIC SERVICES		
D5850	Tissue Conditioning, Maxillary	0	
D5851	Tissue Conditioning, Mandibular	0	
D5863	Overdenture - Complete Maxillary	0	
D5864	Overdenture - Partial Maxillary	0	
D5865	Overdenture - Complete Mandibular	0	
D5866	Overdenture - Partial Mandibular	0	
	FIXED PARTIAL DENTURE PONTICS		
D6205	Pontic - Indirect Resin Based Composite	0	
D6210	Pontic-Cast High Noble Metal	0	◆
D6211	Pontic-Cast Predominatly Base Metal	0	
D6212	Pontic-Cast Noble Metal	0	◆
D6214	Pontic - Titanium	0	
D6240	Pontic-Porcelain Fused To High Noble Metal	0	◆
D6241	Pontic-Porcelain Fused To Predominantly Base Metal	0	
D6242	Pontic-Porcelain Fused To Noble Metal	0	◆
D6245	Pontic - Procelain/Ceramic	0	
D6250	Pontic, Resin With High Noble Metal	0	◆
D6251	Pontic, Resin With Predominantly Base Metal	0	
D6252	Pontic, Resin With Noble Metal	0	◆
	FIXED PARTIAL DENTURE RETAINTERS - INLAYS/ONLAYS		
D6545	Retainer-Cast Metal For Resin Bonded Fixed Prosthesis	0	
D6548	Retainer - Porcelain/Ceramic For Resin Bonded Fixed Prosthesis	0	
D6549	Resin Retainer - For Resin Bonded Fixed Prosthesis	0	
D6602	Retainer Inlay - Cast High Noble Metal, Two Surfaces	0	◆
D6603	Retainer Inlay - Cast High Noble Metal, Three Or More Surfaces	0	◆

ADA Code	ADA Description	Member Pays $	
FIXED PARTIAL DENTURE RETAINTERS - INLAYS/ONLAYS			
D6604	Retainer Inlay - Cast Predominantly Base Metal, Two Surfaces	0	
D6605	Retainer Inlay - Cast Predominantly Base Metal, Three Or More Surfaces	0	
D6606	Retainer Inlay - Cast Noble Metal, Two Surfaces	0	◆
D6607	Retainer Inlay - Cast Noble Metal, Three Or More Surfaces	0	◆
D6610	Retainer Onlay - Cast High Noble Metal, Two Surfaces	0	◆
D6611	Retainer Onlay - Cast High Noble Metal, Three Or More Surfaces	0	◆
D6612	Retainer Onlay - Cast Predominantly Base Metal, Two Surfaces	0	
D6613	Retainer Onlay - Cast Predominantly Base Metal, Three Or More Surfaces	0	
D6614	Retainer Onlay - Cast Noble Metal, Two Surfaces	0	◆
D6615	Retainer Onlay - Cast Noble Metal, Three Or More Surfaces	0	◆
D6624	Retainer Inlay - Titanium	0	
D6634	Retainer Onlay - Titanium	0	
FIXED PARTIAL DENTURE RETAINERS - CROWNS			
D6710	Retainer Crown - Indirect Resin Based Composite	0	
D6720	Retainer Crown, Resin With High Noble Metal	0	◆
D6721	Retainer Crown, Resin With Predominantly Base Metal	0	
D6722	Retainer Crown, Resin With Noble Metal	0	◆
D6740	Retainer Crown - Porcelain/Ceramic	0	
D6750	Retainer Crown, Porcelain Fused To High Noble Metal	0	◆
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	0	
D6752	Retainer Crown, Porcelain Fused To Noble Metal	0	◆
D6780	Retainer Crown, 3/4 Cast High Noble Metal	0	◆
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	0	
D6782	Retainer Crown - 3/4 Cast Noble Metal	0	◆
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	0	
D6790	Retainer Crown, Full Cast High Noble Metal	0	◆
D6791	Retainer Crown, Full Cast Predominantly Base Metal	0	
D6792	Retainer Crown, Full Cast Noble Metal	0	◆
D6794	Retainer Crown - Titanium	0	
OTHER FIXED PARTIAL DENTURE SERVICES			
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	0	
D6940	Stress Breaker	0	
D6950	Precision Attachment	0	
D6980	Fixed Partial Denture Repair Necessitated By Restorative Material Failure	0	
EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)			
D7111	Extraction, Coronal Remnants - Deciduous Tooth	0	
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	0	
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)			

ADA Code	ADA Description	Member Pays $
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)		
D7210	Extraction, Erupted Tooth Requiring Removal Of Bone And/Or Sectioning Of Tooth, And Including Elevation Of Mucoperiosteal Flap If Indicated	0
D7220	Removal Of Impacted Tooth - Soft Tissue	0
D7230	Removal Of Impacted Tooth - Partially Bony	0
D7240	Removal Of Impacted Tooth - Completely Bony	0
D7241	Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	0
D7250	Removal Of Residual Tooth Roots (Cutting Procedure)	0
D7251	Coronectomy-Intentional Partial Tooth Removal	0
OTHER SURGICAL PROCEDURES		
D7280	Exposure Of An Unerupted Tooth	0
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	0
D7285	Incisional Biopsy Of Oral Tissue-Hard (Bone, Tooth)	0
D7286	Incisional Biopsy Of Oral Tissue-Soft	0
D7288	Brush Biopsy - Transepithelial Sample Collection	45
ALVEOLOPLASTY (surgical preparation of ridge for dentures)		
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	0
D7311	Alveoloplasty In Conjuction With Extractions - One To Three Teeth Or Tooth Spaces, Per Quandrant	0
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	0
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth Or Tooth Spaces, Per Quadrant	0
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS		
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	0
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Greater Than 1.25 Cm	0
EXCISION OF BONE TISSUE		
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	0
D7472	Removal Of Torus Palatinus	0
D7473	Removal Of Torus Mandibularis	0
D7485	Reduction Of Osseous Tuberosity	0
SURGICAL INCISION		
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	0
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated (Includes Drainage Of Multiple Fascial Spaces)	0
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue	0
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated (Includes Drainage Of Multiple Fascial Spaces)	0
REPAIR OF TRAUMATIC WOUNDS		
D7910	Suture Of Recent Small Wounds Up To 5 Cm	0

ADA Code	ADA Description	Member Pays $
	OTHER REPAIR PROCEDURES	
D7960	Frenulectomy - Also Known As Frenectomy Or Frenotomy - Separate Procedure Not Incidental To Another Procedure	0
D7963	Frenuloplasty	0
D7970	Excision Of Hyperplastic Tissue - Per Arch	0
D7971	Excision Pericoronal Gingival	0
	LIMITED ORTHODONTIC TREATMENT	
D8010	Limited Orthodontic Treatment Of Primary Dentition	1500
D8020	Limited Orthodontic Treatment Of Transitional Dentition	1500
D8030	Limited Orthodontic Treatment Of Adolescent Dentition	1500
D8040	Limited Orthodontic Treatment Of The Adult Dentition	1500
	INTERCEPTIVE ORTHODONTIC TREATMENT	
D8050	Interceptive Orthodontic Treatment Of Primary Dentition	1500
D8060	Interceptive Orthodontic Treatment Of Transitional Dentition	1500
	COMPREHENSIVE ORTHODONTIC TREATMENT	
D8070	Comprehensive Orthodontic Treatment Of Transitional Dentition	1500
D8080	Comprehensive Orthodontic Treatment Of Adolescent Dentition	1500
D8090	Comprehensive Orthodontic Treatment Of Adult Dentition	2000
	MINOR TREATMENT TO CONTROL HARMFUL HABITS	
D8210	Removable Appliance Therapy For Control Of Harmful Habits	750
D8220	Fixed Appliance Therapy For Control Of Harmful Habits	750
	OTHER ORTHODONTIC SERVICES	
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	15
D8670	Periodic Orthodontic Treatment Visit	0
D8680	Orthodontic Retention (Removal Of Appliances, Construction And Placement Of Retainer(S)	240
✞	Orthodontic Records Fee	265
	UNCLASSIFIED TREATMENT	
D9110	Palliative (Emergency) Treatment Of Dental Pain, Minor Procedures	0
D9120	Fixed Partial Denture Sectioning	0
	ANESTHESIA	
D9210	Local Anesthesia (Not In Conjunction With Operative Or Surgical Procedures)	0
D9211	Regional Block Anesthesia	0
D9212	Trigeminal Division Block Anesthesia	0
D9215	Local Anesthesia In Conjunction With Operative Or Surgical Procedures	0
D9219	Evaluation For Deep Sedation Or General Anesthesia	0
D9223	Deep Sedation/General Anesthesia - Each 15 Mintue Increment	80
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each 15 Minute Increment	85
	PROFESSIONAL CONSULTATION	

ADA Code	ADA Description	Member Pays $
	PROFESSIONAL CONSULTATION	
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician Other Than Requesting Dentist Or Physician	0
D9311	Consultation With A Medical Health Care Professional	0
	PROFESSIONAL VISITS	
D9430	Office Visit For Observation (During Regularly Scheduled Hours) - No Other Services Performed	0
D9440	Office Visit After Regularly Scheduled Hours	40
D9450	Case Presentation, Detailed And Extensive Treatment Planning	0
	MISCELLANEOUS SERVICES	
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
D9940	Occlusal Guards, By Report	95
D9942	Repair And/Or Reline Of Occlusal Guard	15
D9943	Occlusal Guard Adjustment	24
D9951	Occlusal Adjustment (Limited)	0
D9952	Occlusal Adjustment (Complete)	0
D9986	Missed Appointment	20
D9987	Cancelled appointment	20
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
	BLEACHING	
D9975	External Bleaching For Home Application, Per Arch, Includes Materials And Fabrication Of Custom Trays	125

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 & LIMITATIONS

EXCLUSIONS:

Except as specifically provided in this 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 outside of the office in which the Member is enrolled and which are not pre-authorized by the Company (including specialty care services).
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 eligibility under 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. That do not meet accepted standards of dental treatment, which are Experimental or Investigative in nature or are considered enhancements to standard dental treatment as determined by the Company.
8. For hospitalization and associated costs for rendering services in a hospital.
9. Determined by the Company to be the responsibility of Worker's Compensation or employer's liability or health care plan, or payable under any Federal Government or state program, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy, or for services for which benefits are payable under any other insurance.
10. For prescription or non-prescription drugs, home care items, vitamins or dietary supplements.
11. Which are principally Cosmetic in nature, including, but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures as determined by the Company.
12. For diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint (TMJ) syndrome 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.
13. 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.
14. That restore tooth structure lost due to attrition, erosion or abrasion.
15. For replacement of lost, missing, stolen or damaged prosthetic device or orthodontic appliance or for duplicate dentures, prosthetic devices or any duplicative device.
16. 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 twenty-four (24) months.
17. For implants, surgical insertion and/or removal of, and any appliances and/or prosthetics attached to implants.
18. Required because of, or in connection with, acts of war, declared or undeclared.
19. For elective procedures, including, but not limited to, prophylactic extractions of third molars.

LIMITATIONS

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

1. Referral to a Specialty Care Dentist is limited to orthodontics, oral surgery, periodontics, endodontics, and pediatric dentists.
2. Coverage for referral to a pediatric Specialty Care Dentist ends on a Member's 7th birthday. However, exceptions for physical or mental handicaps or medically compromised children, when confirmed by a physician, may be considered on an individual basis with prior approval from the Company.
3. Member 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. This limitation only applies to subscriber termination, not group termination.
4. Sealants – one (1) per tooth per three (3) year period through age ten (10) on permanent first molars and through age fifteen (15) on permanent second molars.
5. In the case 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.
6. Periodontal maintenance following active periodontal therapy - two (2) per twelve (12) consecutive months in combination with routine prophylaxis.
7. Periodontal scaling and root planing - one (1) per twenty-four (24) consecutive month period per area of the mouth.
8. Surgical periodontal procedures - one (1) per thirty-six (36) consecutive month period per area of the mouth.
9. Root canal retreatment – one (1) per tooth per lifetime.
10. Panoramic or full mouth x-rays - one (1) every three (3) years.
11. One (1) set of bitewing x-rays per six (6) consecutive months.
12. Prophylaxis - one (1) per six (6) consecutive months, unless otherwise specified in the Schedule of Benefits.
13. Fluoride treatment - one (1) per six (6) consecutive months through age eighteen (18).
14. Crown lengthening - one (1) per tooth per lifetime.
15. Denture relining or rebasing - integral if provided within six (6) months of insertion by the same dentist. This limitation does not apply to immediate dentures.
16. Subsequent denture relining or rebasing - limited to one (1) every thirty-six (36) consecutive months thereafter.
17. 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).

NEW MEMBER CONTINUATION OF CARE INFORMATION

Continuation of Care:

If You have been receiving care from a dental care provider, You may have a right to keep Your dental care provider for a designated time period. Please contact this Plan's customer service department at 1-866-357-3304, and if You have further questions, You are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov. You may also obtain a copy of our policy on continuation of care from our customer service department. This policy does not apply to a newly covered enrollee covered under an individual subscriber agreement.

You must make a specific request to continue under the care of Your current provider. We are not required to continue Your care with that provider if You are not eligible under our policy or if we cannot reach agreement with your provider on the terms regarding Your care in accordance with California law.

"You have a right to language assistance services at no charge to you, including translation of certain plan documents in Spanish and interpretation in any language regarding your dental treatment. If you need language assistance for dental care or if you want to tell us your spoken and written language preference, please call United Concordia at (866) 357-3304 or visit our website at www.unitedconcordia.com or inform your dentist."

"Usted tiene derecho a servicios de asistencia idiomática sin cargo alguno, incluso a la traducción de ciertos documentos del plan al español e interpretación a cualquier idioma en lo que respecta a su tratamiento dental. Si necesita asistencia idiomática durante su atención dental o quiere indicarnos en qué idioma prefiere que se le hable y escriba, llame a United Concordia al (866) 357-3304, visite nuestro sitio de Internet en www.unitedconcordia.com o informe a su dentista."