UNITED CONCORDIA
Insuring America's Dental Health

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 Web site at www.unitedconcordia.com or inform your dentist.

Usted tiene derecho a recibir 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.

United Concordia Dental Plans of California, Inc.

21700 Oxnard Street, Suite 500
Woodland Hills, CA 91367
800-332-0366
www.unitedconcordia.com

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of this dental Plan. The Group dental plan contract must be consulted to determine the exact terms and conditions of coverage.

The Combined Evidence of Coverage and Disclosure Form discloses the terms and conditions of coverage and 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.
A specimen copy of the Plan contract will be furnished on request.

Your Plan Benefits may differ from the coverage outlined in this brochure. Please refer to any inserts enclosed with this brochure.

If you belong to a group with 50 or less employees, please see the Health Plan Benefit and Coverage Matrix insert.

Please read the following information so you will understand how this program works and how benefits may be obtained.

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 for You and any enrolled Dependents 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:

800-332-0366

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

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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.

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. Also referred to as "We", "Our" or "Us".

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

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

Copayments — Those charges set forth in the Schedule of Benefits that the Member is responsible to pay the treating dentist.

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

Covered Service(s) — A service or supply specified in the Schedule of Benefits for which benefits will be covered subject to the Benefits section of this Evidence of Coverage, when rendered by 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.

Dependent(s) — Subscriber's spouse or domestic life partner as defined by state law, and any unmarried child or stepchild of a Subscriber or unmarried member of the Subscriber's household resulting from a court order or placement by an administrative agency, enrolled in the Plan:

(a) until the end of the month which he/she reaches age 26; or
(b) until the end of the month which he/she reaches age 26 if he/she is a full-time student at an accredited educational institution and chiefly reliant upon the Subscriber for maintenance and support; or
(c) to any age if he/she is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap 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.
Grace Period	A period of no less than 31 days after Premium payment is due under the Contract, in which the Contractholder may make such payment and during which the protection of the Group Contract continues, subject to 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.
In-Network Dentist	A Primary Dental Office or a Specialty Care Dentist.
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)	Subscriber and their Dependent(s).
Out-of-Network Dentist / Non-Participating Provider	A general or specialty care dentist who has not signed a contract with the Company.
Plan	Dental benefits pursuant to this Evidence of Coverage and attached Schedule of Exclusions and Limitations Schedule of Benefits.
Premium	Payment that the Contractholder must remit to the Company in exchange for coverage of the Contractholder's Members.
Primary Dental Office/Provider	Approved office of a Primary Dentist who has executed a contract with the Company and who offers dental services to Members.
Primary Dentist	A general dentist whose office has executed a contract with the Company, under which he/she agrees to provide those dental services listed in the Schedule of Benefits to Members for a monthly fee plus any applicable supplements and Copayments, as payment in full for services rendered.
Renewal Date	The date on which the Group Contract renews. Also known as anniversary date.
Schedule of Benefits	Attached summary of Covered Services and Copayments applicable to benefits payable under the Plan.
Schedule of Exclusions and Limitations	Attached list of Exclusions and Limitations Applicable to benefits, services, supplies or changes under the Plan.

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 the Company to accept negotiated fees plus any applicable Copayments, as payment in full for Covered Services provided to Members.
Subscriber	An eligible individual who has enrolled him/herself and his/her Dependents for dental coverage and for whom Premium payments are due and payable. Also referred to as "You" or "Your" or "Yourself".
Terminated Provider	A doctor that formerly delivered services under contract that is no longer associated with the Plan.
Termination Date	The date on which the dental coverage ends for a Member or the Group Contract terminates.

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

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

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

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

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

The Company is not liable to pay benefits for any services started prior to a Member's Effective Date of coverage. Multi-visit procedures are considered "started" when the 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.

Enrollment Changes

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

- birth of a child;
- adoption of a child;
- court order of placement or custody of a child;
- change in student status for a child;
- marriage of the Subscriber;
- domestic partnership of the Subscriber,

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

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

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

For an enrolled Dependent child who is a full-time student, evidence of his/her student status and reliance on You for maintenance and support must be furnished to Us within 30 days after said Dependent attains the limiting age shown in the definition of Dependent. Such evidence will be requested annually thereafter until the Dependent reaches the limiting age for students and his/her coverage ends.

For an enrolled Dependent child who is mentally or physically handicapped, evidence of his/her reliance on You for maintenance and support due to his/her condition must be supplied to Us within 30 days after said Dependent attains the limiting age shown in the definition of Dependent. If the Dependent is a full-time student at an accredited educational institution, the evidence must be provided within 30 days after the Dependent attains the limiting age for students. Such evidence will be requested based on information provided by the Member's physician but no more frequently than annually.

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

- death of the Subscriber or a Dependent; or
- divorce or dissolution of domestic partnership of the Subscriber; or
- for a child, reaching the limiting age specified in the definition of Dependent;

Late Enrollment

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

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

When You enroll for dental coverage, You must select a Primary Dental Office for Yourself and Your Dependents. Your Dependents do not have to choose the same office as Yours or each others'. If You or Your Dependents do not select an office at enrollment, You will be assigned to an office 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 *Find a Dentist* on Our website at www.unitedconcordia.com or call Our Interactive Voice Response System at the toll-free number in the Introduction section of this Evidence of Coverage, 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. When You call the office to schedule an appointment, let the office know You have United Concordia coverage. When You visit the dental office, present Your ID card or let the office know Your ID number, Plan number and Group number. If Your dentist has questions about Your eligibility or benefits, instruct the office to call Our Interactive Voice Response System toll-free or visit *Dental Inquiry* on Our website at www.unitedconcordia.com.

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. If You have services performed by an Out-of-Network Dentist, services will not be covered under this Plan. 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.

Subsequent Providers

You or Your Dependents may request to change Primary Dental Offices at any time. To make a change, call our Customer Service center toll-free at the number in the Introduction section of this Evidence of Coverage or visit Our website at www.unitedconcordia.com. You will be informed of the date Your transfer will become effective. The newly selected office will also be notified. Your new provider must be effective prior to seeking services from the new Primary Dental Office.

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.

Specialty Care Dentists are reimbursed 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 on the front of this Evidence of Coverage.

Continuity of Care

Current Members:
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 800-332-0366 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 provider 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:
A New Member 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 800-332-0366 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.

Referrals

The Primary Dental Office will coordinate dental care for You and Your Dependents. There are no claim forms required from You. In order for dental services to be covered, care must be provided by Your assigned Primary Dentist, or by a Specialty Care Dentist to whom You have a written referral from Your Primary Dentist. The 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 next section entitled Dental Emergency for details on this situation.

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 pediatric 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.

Dental Emergency

A Dental Emergency is a situation where You have severe pain, swelling, or bleeding in or around Your mouth. 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 the Customer Service Unit to verify coverage at the telephone number listed on the front of this Evidence of Coverage. Obtain an itemized bill from the dental office to submit to the address in the Introduction Section of this Evidence of Coverage. 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. Members must return to their Primary Dental Office for any necessary follow-up care.

Member Reimbursement Provisions

In the event that a Primary Dental Office or Specialty Care Dentist is not available, the Company may authorize treatment by an Out-of-Network Dentist. The Member is liable for only the applicable Copayment, as indicated in the appropriate Schedule of Benefits for the Member. If the Member has paid the Out-of-Network Dentist, the Company will reimburse the Subscriber the difference between the charge and the Copayment as listed in the appropriate Schedule of Benefits. Members should submit a claim form to the address noted on the front of this Evidence of Coverage within 60 days of obtaining the authorization for treatment as described above or within 60 days for a Dental Emergency received from 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 at www.unitedconcordia.com.

Liability of Members in the Event of Non-payment

All contracts between the Company and the Primary Dentist or Specialty Care Dentist state that under no circumstances shall the Member be liable to any dentist for any sum owed by the Company to the dentist. In any instance where the Company fails or refuses to pay the dentist, such dispute is solely between the dentist and the Company, and the Member is not liable for any monies the Company fails or refuses to pay.

BENEFITS

Schedule of Benefits

Your benefits are detailed in the Schedule of Benefits attached to this Evidence of Coverage. Your Schedule of Benefits shows:

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

Your Out-of-Pocket Costs

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

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

Services listed on the Schedule of Benefits are also subject to Exclusions and Limitations. Be sure to review the Schedule of Benefits attached to this Evidence of Coverage.

Other Charges

You are responsible for charges as listed on the Schedule of Benefits. Services not listed on the Schedule of Benefits are not covered and are Your responsibility.

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 out Customer Service Department at 800-332-0366 or Your insurance broker. To fully understand Your coverage, You may wish to carefully review this Evidence of Coverage.*

Dental Services

This section provides brief descriptions of the most common types of services provided by dentists. If a service is listed below does not mean it is a covered service under in Your specific Plan. This list is not all-inclusive. You must review Your Schedule of Benefits and Exclusions and Limitations to determine Your Covered Services.

Exams for diagnosis: inspection of the inside of the mouth by a dentist to identify any disease that needs treatment.

X-rays for diagnosis: the type and amount of x-rays taken for the dentist to identify any disease that needs treatment.

- Bitewing x-rays check-up x-rays of both the upper and lower teeth, usually isolated to the back teeth only, taken with the patient biting the teeth together.
- Panoramic or full mouth x-rays x-rays that scan both the bone and teeth of the entire upper and lower jaws to identify any disease that needs treatment.

Routine Prophylaxis: standard teeth cleaning and polishing.

Periodontal maintenance: "deep" cleaning done on check-up visits after treatment for gum disease.

Sealants: plastic coating placed on the biting areas of the back teeth to help prevent decay from forming.

Fluoride treatment: a highly concentrated chemical placed on the teeth to make them resistant to decay.

Palliative Treatment: procedures to relieve pain.

Space Maintainers: metal and/or acrylic devices used to prevent tooth movement.

Basic Restorative: procedures used to treat caries (cavities, tooth decay) – e.g. amalgam(s), resin fillings, stainless steel crowns, crown build-ups and posts and cores.

Endodontics: treats the dental pulp, pulp chamber and root canal – root canal treatment and retreatment, pulpotomy, pulpal therapy, apicoectomy, and apexification.

- Pulpal therapy: a type of root canal done on primary teeth.

Non-surgical Periodontics: for non-surgical treatment of diseases of the gums and bones supporting the teeth – periodontal scaling and root planing, periodontal maintenance

Periodontal scaling and root planning: a "deep cleaning" to remove tartar from the roots of the teeth, usually done in multiple appointments and with local anesthesia.

Simple Extractions: non-surgical removal of teeth and roots

Surgical Periodontics: surgery done to treat gum disease.

- Gingivectomy: removal of excess gum tissue
- Osseous surgery: gum surgery to treat gum disease and bone loss

Inlays, Onlays, Crowns:

- Inlay: a dental filling that is made from an impression of the tooth, in a laboratory and cemented into the tooth.
- Onlay: a type of conservative crown that covers the biting surface of the tooth but only partially covers the sides of the tooth.
- Crown: a cap that usually covers the entire exterior surface of the tooth.

Prosthetics:

- Fixed bridges: an appliance that replaces one or more missing tooth by being cemented or bonded onto anchoring teeth that are next to the missing tooth/teeth.
- Partial denture: a removable appliance that replaces missing teeth and anchors onto the remaining teeth in either the upper or lower jaw.
- Complete dentures: a removable appliance that replaces all the teeth in either the upper or lower jaw.

Orthodontics:

- for treatment of poor alignment and occlusion – diagnostic x-rays, active treatment and retention for eligible dependent children.

Exclusions

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

Alternative Treatment

All diagnosis and treatment planning is provided by Your Primary Dental Office. Occasionally, You and Your Primary Dental Office may consider possible alternative treatment plans. In those instances, where You agree to an alternative treatment plan as opposed to the Covered Service, 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.

The Primary Dental Office should discuss and provide the costs and receive 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 with In-Network Dentists is based on contracted allowances.

All contracts between the Company and the In-Network Dentist states that under no circumstances will the Member be liable for any sum owed by the Company to the dentist. In any instance where the Company fails or refuses to pay the dentist, such dispute is solely between the dentist and the Company. The Member is not liable for any monies the Company fails or refuses to pay.

The Company maintains claim and eligibility records required by federal and state law. The Company maintains physical, electronic, and procedural safeguards to guard claims and eligibility information from unauthorized access, use, and disclosure.

Coordination of Benefits (COB)

If You or Your Dependents are covered by any other dental plan and receive a service covered by This Plan and the Other Dental Plan, benefits will be coordinated. This means that one plan will be 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. The following words and phrases regarding the Coordination of Benefits ("COB") provision are defined as set forth below:

   A) **Allowable Amount** is the Plan's allowance for items of expense, when the care is covered at least in part by one or more Plans covering the Member for whom the claim is made. 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 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.

Workers' Compensation

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

Review of a Benefit Determination

If You are not satisfied with the administration of Your Plan's benefit, please contact Our Customer Service Department at the toll-free telephone number in the Introduction section of this Evidence of Coverage. If, after speaking with a Customer Service representative, You are still dissatisfied, refer to the following Second Opinion and Dispute 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 Dental 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 the Member has questions on the reasonableness or necessity of recommended surgical procedures;
2. If the Member has 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 the Member requests an additional diagnosis;
4. If the treatment plan in progress is not improving the dental condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment; or
5. If the Member has 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 a Member's condition is such that the Member faces an imminent and serious threat to his or her 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 the Member's 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 72 hours from the receipt of the request, whenever possible. These written guidelines regarding timelines for responding to second opinion requests are available to Plan Members upon request.

The cost of an authorized second opinion will be the responsibility of the Plan, minus any applicable patient Copayment to be paid by the Member at the time of service. Non-authorized second opinions are the sole financial responsibility of the Member.

An authorized second opinion will be provided by an appropriately qualified contracted provider of the Member's choice. If no other Plan provider is reasonably available who meets this standard, then the Plan will authorize an out-of-network second opinion. Second opinions are not covered with out-of-network providers without prior approval of the Plan.

If a request for second opinion is denied by the Plan, the Member may file a grievance following the Grievance Resolution Procedure.

GRIEVANCE RESOLUTION PROCEDURE

Any Member not satisfied with any aspect of United Concordia may file a written complaint/grievance. While United Concordia prefers the complaint/grievance to be filed by the Member in writing due to the more concise nature of written statements as compared to verbal statements, complaints/grievances may be submitted verbally with the assistance of a United Concordia representative. Assistance with filing a complaint/grievance is provided, as necessary, at each location where complaints/grievances may be filed. The Member, or a person acting on the Member's behalf, must file a complaint/grievance within 180 days following the incident(s) or action(s) that is(are) the subject(s) of the enrollee's dissatisfaction. The complaint/grievance should contain sufficient detail to identify the nature of the problem.

A letter or completed United Concordia Dissatisfaction Report must be submitted to the Customer Services Department at: P.O. Box 10194, Van Nuys, CA 91410-0194, or via United Concordia's website www.unitedconcordia.com, or You may call Customer Service at 800-332-0366 for assistance.

A Member who files a complaint/grievance will not be subject to discrimination, disenrollment, or otherwise penalized for filing a grievance.

Complaint/Grievance forms and a description of the complaint/grievance procedure are available directly from United Concordia, on United Concordia's website www.unitedconcordia.com 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 30 days. A notice of the disposition for the complaint/grievance will be sent to the Member within 30 days from the receipt of the complaint/grievance.

A Member may file a complaint/grievance with the Department of Managed Health Care (DMHC) if no response is received from United Concordia within 30 days or as soon as a written decision has been rendered, or any time in any case determined by the DMHC to be a case involving imminent and serious threat to the health of the patient, 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.

For Members who are not proficient in English, who are hearing impaired, who are visually impaired, or who are otherwise impaired such that access to United Concordia's complaint/grievance system is potentially hampered, United Concordia provides 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 800-332-0366.

In the event that an expedited complaint/grievance is filed that involves an imminent or serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, United Concordia will conduct an expedited review of the complaint/grievance. Upon United Concordia's notice of an expedited review case, United Concordia will immediately inform the Member of his/her right and method to notify the DMHC of the complaint/grievance. United Concordia also will notify the Member 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 United Concordia.

"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 800-332-0366 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 Evidence of Coverage 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 also be cancelled or terminated at any time based upon the Termination of Benefits Section below.

TERMINATION OF BENEFITS

Your coverage and/or Your Dependents' coverage will end at 12:01 AM PST:

- on the date You lose eligibility under Your Group's eligibility requirements; or
- on the date Premium payment ceases for You and/or Your Dependents, as specified by Your Group; or
- on the date Your Dependent(s) cease to meet the requirements in the definition of Dependent in the Definitions section of this Evidence of Coverage; or
- on the postmark date We provide notice to You of a final disposition of a fraud conviction by You or Your Dependents; or
- on the date of a change of the Subscriber's residence to an area outside the State of California. Coverage shall continue for Dependents who reside in California with a non-custodial parent.

If Your coverage or Your Dependents' coverage is terminated as described above, coverage for completion of a dental procedure requiring two or more visits on separate days will be extended for a period of 90 days after the Member's Termination Date in order for the procedure to be finished. The procedure must be started prior to the Member's Termination Date. The procedure is considered "started" when the 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. For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Member's Termination Date.

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

Coverage shall remain in effect for 31 days after the due date of the Premium. 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.

FEDERAL COBRA

Federal law may require certain employers to offer continuation coverage to Members for a specified period of time upon termination of employment or reduction of work hours for any reason other than gross misconduct. You should contact Your employer to find out whether or not this requirement applies to You

and Your employer. Your employer will advise You of Your rights to continuation coverage and the cost. If this requirement does apply, You must elect to continue coverage within 60 days from Your qualifying event or notification of rights by Your employer, whichever is later. You may elect to extend Dependent(s') coverage, or the Dependent(s) may elect to continue coverage under certain circumstances or qualifying events. Dependent(s) must elect to continue coverage within 60 days from the event or notification of rights by Your employer, whichever is later. You must pay the required premium for continuation coverage directly to Your employer. The Company is not responsible for determining who is eligible for continuation coverage.

GENERAL PROVISIONS

This 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 subject matter. The failure of any section or subsection of this Evidence of Coverage shall not affect the validity, legality and enforceability of the remaining sections.

The Company may assign this Evidence of Coverage, with the approval of the Department of Managed Health Care (or its successors) 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.

Confidentiality of Dental Records

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

The Company welcomes suggestions and comments to improve the service for this Plan. Members may submit questions and comments to the Company's 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.

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.

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 1121

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 Evidence 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 Evidence of Coverage and the 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 three 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
D0180	Comprehensive periodontal evaluation - new or established patient	0
	RADIOGRAPHS/DIAGNOSTIC IMAGING	
	(including interpretation)	
D0210	Intraoral - complete series (including bitewings)	0
D0220	Intraoral - periapical first film	0
D0230	Intraoral - periapical each additional film	0
D0240	Intraoral - occlusal film	0
D0250	Extraoral - first film	0
D0260	Extraoral - each additional film	0
D0270	Bitewing - single film	0
D0272	Bitewings - two films	0
D0273	Bitewings - three films	0
D0274	Bitewings - four films	0
D0277	Vertical bitewings - 7 to 8 films	0
D0330	Panoramic film	0
D0340	Cephalometric film	0
D0350	Oral/facial photographic images	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	15
D0418	Analysis of saliva sample	15
D0421	Genetic test for susceptibility to oral disease	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 transmision of written report	0
D0502	Other oral pathology procedures, by report	0
	DENTAL PROPHYLAXIS	
D1110	Prophylaxis - adult	0
D1120	Prophylaxis - child	0
	TOPICAL FLUORIDE TREATMENT	
	(office procedure)	
D1203	Topical application of fluoride - child	0
D1204	Topical application of fluoride - adult	0
D1206	Topical fluoride varnish; therapeutic application for moderate to high risk patients	0
	OTHER PREVENTIVE SERVICES	
D1310	Nutritional counseling for control of dental disease	0
D1320	Tobacco counseling for the control and prevention of oral disease	0
D1330	Oral hygiene instructions	0
D1351	Sealant - per tooth	0
	SPACE MAINTENANCE	
	(passive appliances)	
D1510	Space maintainer - fixed - unilateral	0
D1515	Space maintainer - fixed - bilateral	0
D1520	Space maintainer - removable - unilateral	0
D1525	Space maintainer - removable - bilateral	0
D1550	Re-cementation of space maintainer	0
D1555	Removal of fixed space maintainer	0
	AMALGAM RESTORATIONS	
	(including polishing)	
D2140	Amalgam - one surface, primary or permanent	0
D2150	Amalgam - two surfaces, primary or permanent	0

ADA CODE	ADA DESCRIPTION	Member Pays $
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	26◆
D2520	Inlay - metallic - two surfaces	27◆
D2530	Inlay - metallic - three or more surfaces	28◆
D2542	Onlay - metallic - two surfaces	28◆
D2543	Onlay - metallic - three surfaces	28◆
D2544	Onlay - metallic - four or more surfaces	30◆
	CROWNS - SINGLE RESTORATIONS ONLY	
D2710	Crown - resin-based composite (indirect)	25
D2712	Crown - 3/4 resin-based composite (indirect)	25
D2720	Crown - resin with high noble metal	60◆
D2721	Crown - resin with predominantly base metal	60
D2722	Crown - resin with noble metal	60◆
D2740	Crown - porcelain/ceramic substrate	75
D2750	Crown - porcelain fused to high noble metal	60◆
D2751	Crown - porcelain fused to predominantly base metal	60
D2752	Crown - porcelain fused to noble metal	60◆
D2780	Crown - 3/4 cast high noble metal	60◆
D2781	Crown - 3/4 cast predominantly base metal	60
D2782	Crown - 3/4 cast noble metal	60◆
D2783	Crown - 3/4 porcelain/ceramic	75
D2790	Crown - full cast high noble metal	60◆
D2791	Crown - full cast predominantly base metal	60
D2792	Crown - full cast noble metal	60◆
D2794	Crown - titanium	60
D2799	Provisional crown	0
	OTHER RESTORATIVE SERVICES	
D2910	Recement inlay, onlay, or partial coverage restoration	0
D2915	Recement cast or prefabricated post and core	0
D2920	Recement crown	0
D2930	Prefabricated stainless steel crown - primary tooth	8
D2931	Prefabricated stainless steel crown - permanent tooth	10
D2932	Prefabricated resin crown	10
D2933	Prefabricated stainless steel crown with resin window	10
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	10
D2940	Protective restoration	0
D2950	Core buildup, including any pins	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 (not in conjunction with endodontic therapy)	0
D2957	Each additional prefabricated post - same tooth	10
D2970	Temporary crown (fractured tooth)	15
D2971	Additional procedures to construct new crown under existing partial denture framework	25
D2980	Crown repair, by report	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)	20
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	30
D3330	Endodontic therapy, molar (excluding final restoration)	40
	ENDODONTIC RETREATMENT	
D3346	Retreatment of previous root canal therapy - anterior	0
D3347	Retreatment of previous root canal therapy - bicuspid	0
D3348	Retreatment of previous root canal therapy - molar	0
	APEXIFICATION/RECALCIFICATION PROCEDURES	
D3351	Apexification/recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	80
D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/ calcific repair of perforations, root resorption, pulp space disinfection, etc.)	55
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	55
D3354	Pulpal regeneration – (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration	55
	APICOECTOMY/PERIRADICULAR SERVICES	
D3410	Apicoectomy/periradicular surgery - anterior	0
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	0

ADA CODE	ADA DESCRIPTION	Member Pays $
D3425	Apicoectomy/periradicular surgery - molar (first root)	0
D3426	Apicoectomy/periradicular surgery (each additional root)	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
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 flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	0
D4263	Bone replacement graft - first site in quadrant	120
D4264	Bone replacement graft - each additional site in quadrant	92
D4274	Distal or proximal wedge procedure (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
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	0
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, per report	43
	OTHER PERIODONTAL SERVICES	
D4910	Periodontal maintenance	0
D4920	Unscheduled dressing change (by someone other than treating dentist)	0
	COMPLETE DENTURES	
	(including routine post-delivery care)	
D5110	Complete denture - maxillary	100
D5120	Complete denture - mandibular	100
D5130	Immediate denture - maxillary	120
D5140	Immediate denture - mandibular	120
	PARTIAL DENTURES	
	(including routine post-delivery care)	
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	70
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	70
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	75
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	75
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	86
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	86
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	90
	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	0
D5640	Replace broken teeth - per tooth	0
D5650	Add tooth to existing partial denture	0
D5660	Add clasp to existing partial denture	0
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	49
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	49
	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)	20
D5751	Reline complete mandibular denture (laboratory)	20
D5760	Reline maxillary partial denture (laboratory)	20
D5761	Reline mandibular partial denture (laboratory)	20
D5810	Interim complete denture - maxillary	120
D5811	Interim complete denture - mandibular	120
D5820	Interim partial denture - maxillary	45
D5821	Interim partial denture - mandibular	45
	OTHER REMOVABLE PROSTHETIC SERVICES	
D5850	Tissue conditioning, maxillary	0
D5851	Tissue conditioning, mandibular	0

ADA CODE	ADA DESCRIPTION	Member Pays $
	FIXED PARTIAL DENTURE PONTICS	
D6205	Pontic - indirect resin based composite	75
D6210	Pontic - cast high noble metal	50◆
D6211	Pontic - cast predominantly base metal	50
D6212	Pontic - cast noble metal	50◆
D6214	Pontic - titanium	50
D6240	Pontic - porcelain fused to high noble metal	50◆
D6241	Pontic - porcelain fused to predominantly base metal	50
D6242	Pontic - porcelain fused to noble metal	50◆
D6245	Pontic - porcelain/ceramic	75
D6250	Pontic - resin with high noble metal	50◆
D6251	Pontic - resin with predominantly base metal	50
D6252	Pontic - resin with noble metal	50◆
	FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS	
D6545	Retainer - cast metal for resin bonded fixed prosthesis	70
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	105
D6602	Inlay - cast high noble metal, two surfaces	27◆
D6603	Inlay - cast high noble metal, three or more surfaces	28◆
D6604	Inlay - cast predominantly base metal, two surfaces	27
D6605	Inlay - cast predominantly base metal, three or more surfaces	28
D6606	Inlay - cast noble metal, two surfaces	27◆
D6607	Inlay - cast noble metal, three or more surfaces	28◆
D6610	Onlay - cast high noble metal, two surfaces	28◆
D6611	Onlay - cast high noble metal, three or more surfaces	28◆
D6612	Onlay - cast predominantly base metal, two surfaces	28
D6613	Onlay - cast predominantly base metal, three or more surfaces	28
D6614	Onlay - cast noble metal, two surfaces	28◆
D6615	Onlay - cast noble metal, three or more surfaces	28◆
D6624	Inlay - titanium	28
D6634	Onlay - titanium	30
	FIXED PARTIAL DENTURE RETAINERS - CROWNS	
D6710	Crown - indirect resin based composite	75
D6720	Crown - resin with high noble metal	60◆
D6721	Crown - resin with predominantly base metal	60
D6722	Crown - resin with noble metal	60◆
D6740	Crown - porcelain/ceramic	75
D6750	Crown - porcelain fused to high noble metal	60◆
D6751	Crown - porcelain fused to predominantly base metal	60
D6752	Crown - porcelain fused to noble metal	60◆
D6780	Crown - 3/4 cast high noble metal	60◆
D6781	Crown - 3/4 cast predominantly base metal	60
D6782	Crown - 3/4 cast noble metal	60◆
D6783	Crown - 3/4 porcelain/ceramic	75
D6790	Crown - full cast high noble metal	60◆
D6791	Crown - full cast predominantly base metal	60
D6792	Crown - full cast noble metal	60◆
D6794	Crown - titanium	60
	OTHER FIXED PARTIAL DENTURE SERVICES	
D6930	Recement fixed partial denture	0
D6940	Stress breaker	90
D6950	Precision attachment	135
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	0
D6972	Prefabricated post and core in addition to fixed partial denture retainer	0
D6973	Core build up for retainer, including any pins	0
D6976	Each additional indirectly fabricated post - same tooth	10
D6977	Each additional prefabricated post - same tooth	10
D6980	Fixed partial denture repair, by report	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)	
D7210	Surgical removal of 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	Surgical removal of residual tooth roots (cutting procedure)	0
D7251	Coronectomy – intentional partial tooth removal	0
	OTHER SURGICAL PROCEDURES	
D7280	Surgical access of an unerupted tooth	0
D7283	Placement of device to facilitate eruption of impacted tooth	0
D7285	Biopsy of oral tissue - hard (bone, tooth)	0
D7286	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 conjunction with extractions - one to three teeth or tooth spaces, per quadrant	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 1.25cm	0
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	90
	EXCISION OF BONE TISSUE	
D7471	Removal of lateral exostosis (maxilla or mandible)	40
D7472	Removal of torus palatinus	40
D7473	Removal of torus mandibularis	40
D7485	Surgical reduction of osseous tuberosity	60

ADA CODE	ADA DESCRIPTION	Member Pays $
	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)	15
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)	25
	REPAIR OF TRAUMATIC WOUNDS	
D7910	Suture of recent small wounds up to 5 cm	15
	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 of pericoronal gingiva	0
	LIMITED ORTHODONTIC TREATMENT	
D8010	Limited orthodontic treatment of the primary dentition	1,500
D8020	Limited orthodontic treatment of the transitional dentition	1,500
D8030	Limited orthodontic treatment of the adolescent dentition	1,500
D8040	Limited orthodontic treatment of the adult dentition	1,500
	INTERCEPTIVE ORTHODONTIC TREATMENT	
D8050	Interceptive orthodontic treatment of the primary dentition	1,500
D8060	Interceptive orthodontic treatment of the transitional dentition	1,500
	COMPREHENSIVE ORTHODONTIC TREATMENT	
D8070	Comprehensive orthodontic treatment of the transitional dentition	1,500
D8080	Comprehensive orthodontic treatment of the adolescent dentition	1,500
D8090	Comprehensive orthodontic treatment of the adult dentition	2,000
	MINOR TREATMENT TO CONTROL HARMFUL HABITS	
D8210	Removable appliance therapy	750
D8220	Fixed appliance therapy	750
	OTHER ORTHODONTIC SERVICES	
D8660	Pre-orthodontic treatment visit	30
D8670	Periodic orthodontic treatment visit (as part of contract)	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 procedure	0
D9120	Fixed partial denture sectioning	20
	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
D9220	Deep sedation/general anesthesia - first 30 minutes	160
D9221	Deep sedation/general anesthesia - each additional 15 minutes	68
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	170
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	42
	PROFESSIONAL CONSULTATION	
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	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	
D9940	Occlusal guard, by report	120
D9942	Repair and/or reline of occlusal guard	35
D9951	Occlusal adjustment - limited	0
D9952	Occlusal adjusment - complete	0
★	Broken appointment per 30 minutes (without 24-hour notice)	20
	BLEACHING	
D9972	External bleaching - per arch	125

FOOTNOTES

† 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.

★ Please report under code D9999 “Unspecified adjunctive procedure, by report.”

◆ 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.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

EXCLUSIONS

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

1. Not specifically listed in the Schedule of Benefits as a Covered Service.

2. Provided to Members by Out-of-Network Dentists except when immediate dental treatment is required as a result of a Dental Emergency occurring more than 50 miles from the Member's home.

3. Which in the opinion of the treating dentist, or the Company, are not clinically necessary, or do not have a reasonable, favorable prognosis.

   This exclusion does not apply to Group Contracts and Certificates issued and delivered in Maryland.

4. That are necessary due to lack of cooperation with Primary Dental Office, or failure to comply with a professionally prescribed Treatment Plan.

5. Started or incurred prior to the Member's Effective Date of Coverage with the Company or started after the Termination Date of Coverage with the Company.

6. For consultations by a Specialty Care Dentist for services not specifically listed on the Schedule of Benefits as a Covered Service.

7. Services or supplies that are not deemed generally accepted standards of dental treatment.

8. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

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

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

   For Group Contracts and Certificates delivered in Maryland, only services related to Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

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

9. Services and/or appliances that alter the vertical dimension, including, but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

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

10. That restore tooth structure due to attrition, erosion or abrasion.

11. For periodontal splinting of teeth by any method.

12. For replacement of lost, missing, stolen or damaged prosthetic device or orthodontic appliance or for duplicate dentures, prosthetic devices or any duplicative device.

13. For replacement of existing dentures that are, or can be made serviceable.

14. For prosthetic reconstruction or other services which require a prosthodontist.

15. For assistant at surgery.

16. For elective procedures, including prophylactic extraction of third molars.

17. For congenital mouth malformations or skeletal imbalances, including, but not limited to, treatment related to cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery, including orthodontic treatment, and oral and maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging even if the condition requiring these services involves part of the body other than the mouth or teeth. This exclusion shall not apply to newly born children of Members as defined in the definition of Dependent.

    For Group Contracts and Certificates issued and delivered in Kentucky and Pennsylvania, this exclusion shall not apply to newly born children of Members as defined under the definition of Dependent including newly adoptive children, regardless of age.

For Group Contracts and Certificates issued and delivered in Indiana and New Jersey, this exclusion shall not apply to newly born children of Members as defined under the definition of Dependent.

For Group Contracts and Certificates issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.

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

18. For diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint.

19. For implants, surgical insertion and/or removal of, and any appliances and/or crowns attached to implants.

20. For the following, which are not included as orthodontic benefits: retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient non-cooperation, repair of orthodontic appliances, replacement of lost or stolen appliances, special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders), myofunctional therapy, cases involving orthognathic surgery, extractions for orthodontic purposes, and treatment in excess of 24 months.

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

21. For active orthodontic treatment if started prior to a Member's effective date.

22. For prescription or nonprescription drugs, home care items, vitamins or dietary supplements.

23. For hospitalization and associated costs for rendering services in a hospital.

24. For house or hospital calls for dental services.

25. For any dental or medical services performed by a physician and/or services which benefits are otherwise provided under a health care plan of the employer.

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

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

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

    For Group Contracts and Certificates issued and delivered in Maryland services which are Cosmetic in nature, including, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures.

27. For broken appointments.

28. Arising from any intentionally self-inflicted injury or contusion when the injury is a consequence of the Member's commission of or attempt to commit a felony or engagement in an illegal occupation or of the Member's being intoxicated or under the influence of illicit narcotics.

    This exclusion does not apply to Group Contracts and Certificates issued and delivered in Maryland and Ohio.

29. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the national guard or in the armed forces of any country or international authority.

LIMITATIONS

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

1. Bitewing x-rays – one set(s) per six consecutive months through age 13, and one set(s) of bitewing x-rays per 12 consecutive months for age 14 and older.

2. Panoramic or full mouth x-rays – one per three-year period.

3. Prophylaxis – one per six consecutive month period.

4. Routine prophylaxis and periodontal maintenance procedures are limited to no more than any combination of one per six consecutive month period.

5. Sealants – one per tooth per three year(s) through age 15 on permanent first and second molars.

6. Fluoride treatment – one per six consecutive months through age 18.

7. Space maintainers only eligible for Members through age 18 when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop.

8. Restorations, crowns, inlays and onlays – covered only if necessary to treat diseased or fractured teeth.

9. Crowns, bridges, inlays, onlays, buildups, post and cores – one per tooth in a five-year period.

10. Crown lengthening – one per tooth per lifetime.

11. Referral for specialty care is limited to orthodontics, oral surgery, periodontics, endodontics, and pediatric dentists.

    This limitation does not apply to Group Policies and Certificates issued in Maryland if the service was provided as a result of a standing or non-network referral as described in the Certificate of Coverage.

12. Coverage for referral to a pediatric Specialty Care Dentist ends on a Member’s seventh birthday.

13. Pupal therapy – through age five on primary anterior teeth and through age 11 on primary posterior teeth.

14. Root canal treatment – one per tooth per lifetime.

15. Root canal retreatment – one per tooth per lifetime.

16. Periodontal scaling and root planing – one per 24 consecutive month period per area of the mouth.

17. Surgical periodontal procedures – one per 24 consecutive month period per area of the mouth.

18. Full and partial dentures – one per arch in a five-year period.

19. Denture relining, rebasing or adjustments – are included in the denture charges if provided within six months of insertion by the same dentist.

20. Subsequent denture relining or rebasing – limited to one every 36 consecutive months thereafter.

21. Oral surgery services are limited to surgical exposure of teeth, removal of teeth, preparation of the mouth for dentures, removal of tooth generated cysts up to 1.25cm, frenectomy and crown lengthening.

22. Wisdom teeth (third molars) extracted for Members under age 15 or over age 30 are not eligible for payment in the absence of specific pathology.

23. If for any reason orthodontic services are terminated or coverage under the Company is terminated before completion of the approved orthodontic treatment, the responsibility of the Company will cease with payment through the month of termination.

    For Group Contracts and Certificates issued and delivered in Maryland, services will continue for 60 days after termination if paid monthly, or until the later of 60 days after termination or the end of the quarter in progress if paid quarterly. This extension of orthodontic payment does not apply if coverage was terminated due to failure to pay required Premium, fraud, or if succeeding coverage is provided by another health plan and the cost is less than or equal to the cost of coverage during the extension and there is no interruption of benefits.

24. Orthodontic treatment – not eligible for Members over age 18 unless listed otherwise in the Member's Schedule of Benefits.

25. Comprehensive orthodontic treatment plan – one per lifetime.

26. In the case of a Dental Emergency involving pain or a condition requiring immediate treatment, the Plan covers necessary diagnostic and therapeutic dental procedures administered by an Out-of-Network Dentist up to the difference between the Out-of-Network Dentist's charge and the Member Copayment up to a maximum of $50 for each emergency visit.

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

27. 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).

28. An Alternate Benefit Provision (ABP) may be applied by the Primary Dental Office if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed for the ABP.