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

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

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

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

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

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

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

UNITED CONCORDIA
America's Premier Dental Insurer

# UNITED CONCORDIA INSURANCE COMPANY

## NOTICE: IMPORTANT INFORMATION REGARDING YOUR INSURANCE

**In the event You need to contact someone about this insurance for any reason please contact Your agent or Your Group. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the Company at the following address and telephone number:**

**1800 Center Street, Suite 2B 220**
**Camp Hill, PA 17011**
**800-332-0366**

**If You have been unable to contact or obtain satisfaction from the Company or the agent or Your Group, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:**

**1300 East Main Street**
**Richmond, VA 23219**
**(800) 552-7945 (In-state only) or**
**(877) 310-6560**

**Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent or Your Group, Company or the Bureau of Insurance, have Your policy number available.**

## Dental Plan
## Certificate of Insurance

## Network Plan

## GEOTRANS LLC
## 920816000
## July 1, 2020

## Notice to Florida residents: The benefits of the policy providing your coverage are governed by a state other than Florida.

**If Your Dependents are covered under any other dental plan, that other dental plan may be primary for Your Dependents. Please refer to the Coordination of Benefits section.**

# United Concordia Insurance Company
# CERTIFICATE OF INSURANCE

## INTRODUCTION

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

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

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

800-332-0366

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

*www.unitedconcordia.com*

Claim forms should be sent to:

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

**This Company is subject to regulation in this Commonwealth by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and by the Virginia Department of Health pursuant to Title 32.1.**

# TABLE OF CONTENTS



Attached:

Appeal Procedure Addendum

Schedule of Benefits
Schedule of Exclusions and Limitations

# DEFINITIONS

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

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

**Authorized Entity –** A Health Insurance Marketplace or other entity authorized by law or regulation through which individuals and groups can purchase insurance to meet the requirements of the federal Affordable Care Act.

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

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

**Coinsurance** - Those remaining percentages or dollar amounts of the Maximum Allowable Charge for a Covered Service that are the responsibility of either the Certificate Holder or his/her enrolled Dependents after the Company pays the percentages or dollar amounts shown on the Schedule of Benefits for a Covered Service.

**Company** - United Concordia, the insurer.

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

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

**Cosmetic** - Services or procedures that are not Dentally Necessary and are primarily intended to improve or otherwise modify the Member's appearance.

**Covered Service(s)** - Services or procedures shown on the Schedule of Benefits for which benefits will be covered subject to the Schedule of Exclusions and Limitations, when rendered by a Dentist.

**Deductible(s) -** A specified amount of expenses set forth in the Schedule of Benefits for Covered Services that must be paid by the Member before the Company will pay any benefit.

**Dentally Necessary** - A dental service or procedure is 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. The determination will be made by the Dentist in accordance with guidelines established by the Company. When there is a conflict of opinion between the Dentist and the Company on whether or not a dental service or procedure is Dentally Necessary, the opinion of the Company will be final.

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

**Dependent(s*)*** – Those individuals eligible to enroll for coverage under the Group Policy because of their relationship to the Certificate Holder and any other class of persons as may mutually be agreed upon by the insurer and the group policyholder.

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

1. The Certificate Holder's Spouse and
2. Any natural child, stepchild, adopted child or child placed with the Certificate Holder or the Certificate Holder's Spouse by order of a court or administrative agency:
   (a) until the end of the month that the child reaches age twenty-six (26); or
   (b) until the end of the month that the child reaches age twenty-six (26) if he/she is a full-time student at an accredited educational institution and is chiefly reliant upon the Certificate Holder for maintenance and support; or
   (c) until 12:00 AM on the date 12 months from the date the full-time student ceases to be enrolled or until age 26, whichever comes first, if the full-time student is on a medical leave of absence certified by a physician; or
   (d) to any age if the child is and continues to be both incapable of self-sustaining employment by reason of intellectual disability or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

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

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

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

**Family Policy –** A Group Policy that covers the Policyholder's Certificate Holders and may also cover eligible Dependents, as defined in this Certificate. A Group Policy that covers only Certificate Holders' children is not a Family Policy.

**Grace Period** - A period thirty-one (31) days after Premium payment is due under the Group Policy, except the first premium, in which the Policyholder may make such payment and during which the protection of the Group Policy continues. In advance of the discontinuance of the policy, the Policyholder may provide written notice of termination in accordance with the terms of the policy.

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

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

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

**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 Us and the particular Participating Dentist rendering the service. Depending upon the Plan purchased by the Policyholder, Maximum Allowable Charges for Covered Services rendered by Non-Participating Dentists may be the same or higher than such charges for Covered Services rendered by Participating Dentists in order to help limit Out-of-Pocket Expenses of Members choosing Non-Participating Dentists.

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

**Non-Participating Dentist** - A Dentist who has not signed a contract with Us to accept the Company's Maximum Allowable Charges as payment in full for Covered Services.

**Out-of-Pocket Expense(s)** – Costs not paid by Us, including but not limited to Coinsurance, Deductibles, amounts billed by Non-Participating Dentists that are over the Maximum Allowable Charge, costs of services that exceed the Policy's Limitations or Maximums, or for services that are Exclusions. The Certificate Holder is responsible to pay for Out-of-Pocket Expenses.

**Out-of-Pocket Maximum** – The limit on the Deductibles and Coinsurance for Covered Services provided by Participating Dentists that the Certificate Holder is required to pay in a calendar year or Contract Year, as shown on the Schedule of Benefits. After this limit is reached, Covered Services from Participating Dentists are paid 100% by Us for the remainder of the calendar year or Contract Year unless subject to the Schedule of Exclusions and Limitations.

**Participating Dentist** - A Dentist who has executed a Participating Dentist Agreement with Us, under which he/she agrees to accept the Company's Maximum Allowable Charges as payment in full for Covered Services. Participating Dentists may also agree to limit their charges for any other services delivered to Members.

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

**Policyholder** - Organization that executes the Group Policy. Also referred to as "Your Group".

**Premium** - Payment made by the Policyholder in exchange for coverage of the Policyholder's Members under this Group Policy.

**Renewal Date** - The date on which the Group Policy renews. Also known as "Anniversary Date".

**Schedule of Benefits** - Attached summary of Covered Services, Coinsurances, Deductibles, Waiting Periods and maximums applicable to benefits payable under the Plan.

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

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

**Spouse** – The Certificate Holder's partner by marriage or by any union between two adults that is recognized by law in the state where this Group Policy is issued.

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

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

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

## ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

### New Enrollment

In order to be a Member, You must meet the eligibility requirements of Your Group and this Group Policy. If You are enrolling through an Authorized Entity, You must meet any additional eligibility requirements of that Authorized Entity and supply enrollment information to it. We must receive enrollment information for the Certificate Holder, enrolled Dependents, and Policyholder. Provided that We receive applicable Premium, coverage will begin on the date specified in the enrollment information We receive. Your Group will inform Certificate Holders of its eligibility requirements.

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

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

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

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

## Special Enrollment Periods - Enrollment Changes

After Your Effective Date, You can change Your enrollment during Your Group's open enrollment period. There are also Special Enrollment Periods when the Certificate Holder may add or remove Dependents. These Special Enrollment Period life change events include:

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

If You enrolled through Your Group, to enroll a new Dependent as a result of one of these events, You must supply the required enrollment change information within the Special Enrollment Period that is thirty-one (31) days from the date of the life change event. The Dependent must meet the definition of Dependent applicable to this Group Policy.

If You enrolled through an Authorized Entity, there are additional life change events that may permit You to add or remove Dependents or change Plans. In addition to the life change events noted above, the additional Special Enrollment Period events that apply to participation through an Authorized Entity include changes in:

- state of residence (You are permitted to select a new plan during the period of 60 days prior to or 60 days after a permanent move);
- incarceration status (You are permitted to select a new plan during the period of 60 days prior to or 60 days after change in incarceration status);
- citizenship, status as a national or lawful presence;
- income, except when You did not request from the Authorized Entity an eligibility determination for insurance affordability programs.
- Other qualifying events as defined by an Authorized Entity. These events include, but are not limited to, unintentional, inadvertent, or erroneous enrollments resulting from action by a party other than an Authorized Entity, or loss of dependent status due to divorce, legal separation, dissolution of any legal union between two adults, or death.

Unless otherwise noted above, the Special Enrollment Period during which You must supply the required enrollment change information to the Authorized Entity is thirty (30) days from the date of the life change event. The Dependent must meet the definition of Dependent applicable to this Group Policy.

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 or on the date dictated by the Authorized Entity, as long as the Premium is paid.

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

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 ninety (90) days after the child 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 thirty (31) 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 thirty (31) days after the Dependent attains the limiting age for students. Such evidence will be requested thereafter based on information provided by the Member's physician, but no more frequently than annually.

Dependent coverage may only be terminated when certain life change events occur including death, divorce or dissolution of the union or domestic partnership, reaching the limiting age or during open enrollment periods or when otherwise permitted by any applicable law or regulation intended to implement the federal Affordable Care Act.

### Late Enrollment

If You or Your Dependents are not enrolled within thirty-one (31) days of initial eligibility or during the Special Enrollment Period specified for a life change event, You or Your Dependents cannot enroll until the next Special Enrollment Period or open enrollment period conducted for Your Group unless otherwise permitted by applicable law or regulation intended to implement the federal Affordable Care Act, or specified in any applicable Late Entrant Rider to the Certificate of Insurance. If You are required by court order to provide coverage for a Dependent child, You will be permitted to enroll the Dependent child without regard to enrollment season restrictions.

## HOW THE DENTAL PLAN WORKS

### Choice of Provider

You may choose any licensed Dentist for services. However, Your Out-of-Pocket Expenses will vary depending upon whether or not Your Dentist is in Our network. If You choose a Participating Dentist, You may limit Your Out-of-Pocket Expense. Participating Dentists agree by contract to accept Maximum Allowable Charges as payment in full for Covered Services. Also, if agreed by the provider, Participating Dentists limit their charges for all services delivered to Members, even if the service is not covered for any reason and a benefit is not paid under this Plan. Participating Dentists also complete and send claims directly to Us for processing. To find a Participating Dentist, visit Our website at www.unitedconcordia.com or call Us at the toll-free number in the Introduction section of this Certificate or on Your ID card.

If You use a Non-Participating Dentist, You may have to pay the Dentist at the time of service, complete and submit Your own claims and wait for Us to reimburse You. You will be responsible for the Dentist's full charge which may exceed Our Maximum Allowable Charge and result in higher Out-of-Pocket Expenses.

#### Incontestability

After two years from the date of issue of this Certificate no statement made by any person insured under the Certificate relating to the insurability of the Certificate Holder or their Dependent(s) shall be used to contest the validity of the Certificate unless the statement is contained in a written instrument signed by the insured.

**Entire Contract**

The Group Policy consists of the Certificate of Insurance, Schedule of Exclusions and Limitations, Schedule of Benefits, the Application for Group Dental Insurance, and any individual enrollment forms, including any riders, addenda and/or endorsements. The Group Policy represents the entire agreement between the Policyholder and the Company with respect to the subject matter. A copy of any Application of the Policyholder shall be attached to the Policy when issued. All statements made by the Policyholder or by the persons insured shall be deemed representations and not warranties.

No written statement made by any person insured under this Certificate shall be used to contest the validity of the Policy or the Certificate unless a copy of the statement is furnished to the person or to their beneficiary or personal representative.

**Notice of Claim**

Written notice of claim must be given to the Company within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Insured Person to the Company, or to any authorized agent of the Company, with information sufficient to identify the Insured Person, shall be deemed notice to the Company.

**Claim Forms**

Upon receipt of a notice of claim, We will furnish to the Insured Person such forms as are usually furnished by Us for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after We received notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting within the time fixed in the Policy for filing proof of loss, a written statement covering the occurrence, character, and extent of the loss for which claim is made.

**Proofs of Loss**

Written proof of loss must be furnished to Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

**Time Limit of Benefit Payments**

All benefits payable under this Certificate for any loss other than loss for which this Certificate provides any periodic payment will be paid no later than 30 days from receipt of due written proof of such loss. The Company may extend this 30-day period by no more than 15 days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Company. Subject to due written proof of loss, all accrued indemnities for loss for which this Certificate provides periodic payment will be paid quarterly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Dental Examinations and Autopsy**

The Company at its own expense shall have the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of a claim under this Certificate, and to make an autopsy where it is not prohibited by law.

**Limitation of Action**

No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

**Beneficiary**

Benefits will be payable to the beneficiary designated by the Member.

**Member Rights and Responsibilities**

The Company believes that a mutually respectful relationship among our Members, our providers and our Company is a key element in delivering high quality dental care. This statement underscores our commitment to Members' rights and outlines members' responsibilities.

Member Rights

- Members have the right to receive the Company's policy statement on Members' rights and responsibilities.
- Members have a right to receive information about the services the Company provides and about the providers in the Company's networks.
- Members have a right to privacy that the Company respects and protects.
- Members have a right to participate with providers in the decisions regarding their dental care.
- Members have a right to information about appropriate or dentally necessary treatment without regard to cost or benefit coverage.
- Members have a right to voice complaints about their dental plan or about the care provided.
- Members have the right to appeal decisions that the Company has made that affect their individual care.

Member Responsibilities

- Members have a responsibility to provide, to the extent possible, information that the Company's network providers need in order to provide appropriate dental care.
- Members have a responsibility to follow the treatment plans and instructions for care upon which they and their provider have agreed.

**Right to Information on Payment Arrangements**

Members have the right to obtain information on the types of provider payment arrangements used to compensate providers for health care services rendered to Members. To obtain this information, Members may call the Company's Member Services at 800-332-0366.

# BENEFITS

## Covered Services

Benefits and any applicable Coinsurance, Deductibles, Annual Maximums, Lifetime Maximums, Out-of-Pocket Maximums and Waiting Periods are shown on the attached Schedule of Benefits. Covered Services shown on the Schedule of Benefits must be Dentally Necessary unless otherwise specified in a Rider to this Group Policy and are subject to frequency or age Limitations detailed on the attached Schedule of Exclusions and Limitations.

No benefits will be paid for services, supplies or charges detailed under the Exclusions on the Schedule of Exclusions and Limitations, and no benefits will be paid for services on the Schedule of Benefits with a Coinsurance of zero (0).

## Predetermination

A predetermination is a request for Us to estimate benefits for a dental treatment You have not yet received. Predetermination is not required for any benefits under the Plan. In estimating benefits, We look at patient eligibility, Dental Necessity and the Plan's coverage for the treatment. Payment of benefits for a predetermined service is subject to Your continued eligibility in the Plan. At the time the claim is paid, We may also correct mathematical errors, apply coordination of benefits, and make adjustments to comply with Your current Plan and applicable Annual Maximums, Lifetime Maximums, or Out-of-Pocket Maximums on the date of service**.**

## Payment of Benefits

If You have treatment performed by a Participating Dentist, We will pay covered benefits directly to the Participating Dentist. Both You and the Dentist will be notified of benefits covered, Our payment and any Out-of-Pocket Expenses. Payment will be based on the Maximum Allowable Charge Your Participating Dentist has contracted to accept. Maximum Allowable Charges may vary depending on the geographical area of the dental office and the contract between Us and the particular Participating Dentist rendering the service. **Benefits for covered dental emergency services provided by a Non-Participating Dentist will be paid at the same level that would have been paid had the services been rendered by a Participating Dentist.**

If You receive treatment from a Non-Participating Dentist, We will send payment for Covered Services to You unless You the claim indicates that payment should be sent directly to Your treating Dentist. This is called assignment of benefits, and it is available for care delivered by Non-Participating Dentists outside of Pennsylvania and West Virginia. You will be notified of the services covered, Our payment and any Out-of-Pocket Expenses. You will be responsible to pay the Dentist any difference between Our payment and the Dentist's full charge for the services. Non-Participating Dentists are not obligated to limit their fees to Our Maximum Allowable Charges.

We are not liable to pay benefits for any services started prior to a Member's Effective Date of coverage. Multi-visit procedures are considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. Procedures started prior to the Member's Effective Date are the liability of the Member.

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

## Overpayments

When We make an overpayment for benefits, We have the right to recover the overpayment either from You or from the person or Dentist to whom it was paid. We will recover the overpayment either by requesting a refund or offsetting the amount overpaid from future claim payments. This recovery will follow any applicable state laws or regulations. The Member must provide any assistance necessary, including furnishing information and signing necessary documents, for the Company to be reimbursed.

## Coordination of Benefits (COB)

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

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

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

2. The fair value of services provided by the Company will be considered to be the amount of benefits paid by the Company. The Company will be fully discharged from liability to the extent of such payment under this provision.

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

   A) If the other plan does not have a provision similar to this one, then that plan will be primary.
   B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.
   C) Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:
      1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
      2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
      3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
      4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
   D) Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:
      1) First, the plan of the parent with custody of the child.
      2) Then, the plan of the Spouse of the parent with the custody of the child; and
      3) Finally, the plan of the parent not having custody of the child.
      4) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of

the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.

5) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 3-C) above, titled Dependent Child/Parents Not Separated or Divorced.

E) Active/Inactive Member

1) For actively employed Members and their Spouses over the age of sixty-five (65) who are covered by Medicare, the plan will be primary.
2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.

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

G) The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a Member or a Dependent.

4. Right to Receive and Release Needed Information -- Certain facts are needed to apply these COB rules. The Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Any health information furnished to a third party will be released in accordance with federal law. Each person claiming benefits under This Plan must give any facts needed to pay the claim.

5. Facility of Payment -- A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Company may pay the amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan, and the Company will not pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the services prepaid by the Company.

6. Right of Recovery -- If the payment made by the Company is more than it should have paid under this COB provision, the Company may recover the excess from one or more of the following: (1) persons it has paid or for whom it has paid; or (2) insurance companies; or (3) other organization. Members are required to assist the Company to implement this section.

## Review of a Benefit Determination

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

## Value-Added Programs and Services

From time to time, We offer Members access to various lifestyle, health and/or value-added programs and services. Such offerings are subject to change at any time without notice. Contact Your Group or call Customer Service for eligibility requirements and other information. Eligibility requirements for these programs and services are applied in a uniform, non-discriminatory manner to all Members.

# TERMINATION -- WHEN COVERAGE ENDS

A Member's coverage will end:

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

- when You no longer meet other eligibility requirements imposed by an Authorized Entity; or
- on the termination date specified for You by Authorized Entity.

On the date the Certificate Holder's coverage ends or the Certificate Holder is no longer eligible to enroll his/her Dependents, Dependent coverage will end unless otherwise specified in any applicable addendum or endorsement to this Certificate. If the Group Policy is cancelled, Certificate Holder and Dependent coverage will end on the Group Policy Termination Date.

If the Policyholder fails to pay Premium, coverage will remain in effect during the Grace Period. If the Premium is not received by the end of the Grace Period, the Group Policy will be cancelled and coverage will terminate on the last date for which Premium was paid.

**Benefits After Coverage Terminates**

We are not liable to pay any benefits for services, including those predetermined, that are started after Your Termination Date or after the Group Policy Termination Date. However, coverage for completion of a dental procedure requiring two (2) or more visits on separate days will be extended for a period of ninety (90) days after the Termination Date in order for the procedure to be finished. The procedure must be started prior to the Termination Date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Member's Termination Date. This extension does not apply if the Group Policy terminates for failure to pay Premium.

## CONTINUATION COVERAGE

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

## GENERAL PROVISIONS

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

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

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

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

The pertinent laws and regulations for interpretation and enforcement of the Certificate are the laws and regulations of Virginia.

# VIRGINIA ADDENDUM TO CERTIFICATE

## APPEAL PROCEDURE

This Addendum is effective for Adverse Determinations issued beginning July 1, 2011 or on the Effective Date stated in the Group Policy, whichever is later. It is attached to and made part of the Certificate.

If You are dissatisfied with Our benefit determination on a claim, You may appeal Our decision by following the steps outlined in this procedure. We will resolve Your appeal in a thorough, appropriate, and timely manner to ensure that You are afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the Plan documents and consistently among claimants. You or Your Authorized Representative may submit written comments, documents, records and other information relating to claims or appeals. We will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by Us required under these procedures will be supplied to You or Your Authorized Representative

## DEFINITIONS

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

"Adverse Determination" is a denial, reduction, or termination of or failure to make payment (in whole or in part) for a Claim for Benefits based on a utilization review determination that an item or service otherwise covered under the Plan is Experimental or Investigational or is not Medically Necessary or does not meet Our requirements for Dental Necessity, appropriateness, health care setting or effectiveness.

"Authorized Representative" is a person granted authority by You and the Company to act on Your behalf regarding a Complaint or an appeal of an Adverse Determination. An assignment of benefits is not a grant of authority to act on Your behalf in pursuing and appealing a benefit determination.

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

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

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

"Complaint" means any written communication from a covered person primarily expressing a grievance not related to an Adverse Determination, including a decision resulting in a denial, reduction, or termination of or failure to make payment (in whole or in part) based on a determination of eligibility to participate in a plan or a determination that an item or service otherwise is not covered.

"Final Adverse Determination" means a Utilization Review determination made by a dentist advisor in a reconsideration of an Adverse Determination, and upon which a provider or Member may base an appeal.

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

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

## OFFICE OF MANAGED CARE OMBUDSMAN & VA DEPARTMENT OF HEALTH

The Office of the Managed Care Ombudsman will help Virginia consumers to understand and exercise their rights to file Complaints and appeal Adverse Determinations and Final Adverse Determinations made by the Company.

**If You have questions regarding an appeal or Complaint concerning the dental care services You have been provided which have not been satisfactorily addressed by Your Plan, You may contact the Office of the Managed Care Ombudsman at the following addresses and phone numbers:**

**ADDRESS:** **OFFICE OF THE MANAGED CARE OMBUDSMAN**
**BUREAU OF INSURANCE**
**P.O. BOX 1157**
**RICHMOND, VA 23218**

**TELEPHONE:** **TOLL-FREE: 1-877-310-6560**

**RICHMOND METROPOLITAN AREA: 804-371-9032**

**E-MAIL:** **ombudsman@scc.virginia.gov**

**WEB PAGE:** **INFORMATION REGARDING THE OMBUDSMAN MAY BE FOUND BY ACCESSING THE STATE CORPORATION COMMISSION'S WEB PAGE AT:**

**http://www.scc.virginia.gov/boi**

You may also contact the Office of Licensure & Certification at the Virginia Department of Health for assistance in filing an appeal. They can be reached at:

**Office of Licensure & Certification**
**Virginia Department of Health**
**9960 Mayland Drive, Suite 401**
**Richmond, VA 23233**
**Toll-free Complaint Hotline: 1-800-955-1819**
**Richmond Area: 1-804-367-2106**
**Fax: 1-804-527-4503**
**Email: mchip@vdh.virginia.gov**

## COMPLAINT PROCEDURE

You or Your Authorized Representative may file Complaint with Us within one-hundred eighty (180) days of receiving a decision not related to an Adverse Determination. To file a Complaint, telephone the toll-free number listed in Your Certificate of Insurance or on Your ID card, or contact:

**ADDRESS**: **Dental Customer Service**
**United Concordia Companies Inc.**
**P.O. Box 69414**
**Harrisburg, PA 17106-9414**
**1-800-772-1133**

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

Notice of the Complaint decision will include the following in written or electronic form:

a) the specific reason for the decision;
b) reference to specific plan provisions on which the decision was based;
c) a statement that this is the Company's final decision.
d) a statement that You are entitled to receive upon request and free of charge, reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts;

e) a statement of Your right to bring a civil action under ERISA; and the following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”
f) the address, telephone number and electronic address for the Office of Managed Care Ombudsman, listed above.

## ADVERSE DETERMINATION PROCEDURE FOR PRE-SERVICE CLAIM

**Reconsideration of an Adverse Determination for Pre-Service Claim**
You or Your Authorized Representative, usually Your provider, may request a reconsideration of an Adverse Determination within one-hundred eighty (180) days of receipt of the Adverse Determination. To file for a reconsideration, telephone the toll-free number listed in Your Certificate of Insurance or on Your ID card, or contact:

**ADDRESS**: **Dental Customer Service**
**United Concordia Companies, Inc.**
**P.O. Box 69414**
**Harrisburg, PA 17106-9414**
**1-800-772-1133**

We will review the Adverse Determination and notify You of Our decision within thirty (30) working days of the request for reconsideration. Any dentist advisor involved in reviewing the reconsideration will be different from and not in a subordinate position to the dentist advisor involved in the initial Adverse Determination. If You are dissatisfied with Our Final Adverse Determination after reconsideration, You may file an appeal.

Notice of the decision for Your reconsideration will include the following in written or electronic form:

a) the specific reason for the decision;
b) reference to specific plan provisions on which the decision was based;
c) a statement that You are entitled to receive reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts; All such information is available upon request and is free of charge.
d) a statement of Your right to bring a civil action under ERISA;
e) The following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”
f) a statement that the Member may file an appeal if the initial Adverse Determination was upheld and where to file the appeal;
g) the address and telephone numbers for the Office of the Managed Care Ombudsman, listed above, along with the e-mail address.
h) a statement indicating the Member or their Authorized Representative may file an appeal within one-hundred eighty (180) days.

## ADVERSE DETERMINATION PROCEDURE FOR POST-SERVICE CLAIM

**Reconsideration of an Adverse Determination for Post-Service Claim**
You or Your Authorized Representative, usually Your provider, may request a reconsideration of an Adverse Determination within one-hundred eighty (180) days of receipt of the Adverse Determination. To file for a reconsideration, telephone the toll-free number listed in Your Certificate of Insurance or on Your ID card, or contact:

**ADDRESS**: **Dental Customer Service**
**United Concordia Companies, Inc.**
**P.O. Box 69414**
**Harrisburg, PA 17106-9414**
**1-800-772-1133**

We will review the Adverse Determination and notify You of Our decision within ten (10) working days of the request for reconsideration. Any dentist advisor involved in reviewing the reconsideration will be different from and not in a subordinate position to the dentist advisor involved in the initial Adverse Determination. If You are dissatisfied with Our Final Adverse Determination after reconsideration, You may file an appeal.

Notice of the decision for Your reconsideration will include the following in written or electronic form:

a) the specific reason for the decision;
b) reference to specific plan provisions on which the decision was based;
c) a statement that You are entitled to receive reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts; All such information is available upon request and is free of charge.
d) a statement of Your right to bring a civil action under ERISA;
e) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
f) a statement that the Member may file an appeal if the initial Adverse Determination was upheld and where to file the appeal;
g) the address and telephone numbers for the Office of the Managed Care Ombudsman, listed above, along with the e-mail address.
h) a statement indicating the Member or their Authorized Representative may file an appeal within one-hundred eighty (180) days.

**Appeal of a Final Adverse Determination**

You or Your Authorized Representative may file an appeal with Us within one-hundred eighty (180) days of receipt of a Final Adverse Determination. To file an appeal, telephone the toll-free number listed in Your Certificate of Insurance or on Your ID card, or contact Dental Customer Service at the address and telephone number listed above.

We will review the claim and notify You of Our decision within sixty (60) days of the request for appeal. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial Adverse Decision.

Notice of the appeal decision will include the following in written or electronic form:

a) the specific reason for the appeal decision;
b) reference to specific plan provisions on which the decision was based;
c) a statement that this is the Company's final decision,
d) a statement that You are entitled to receive upon request and free of charge, reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts;
e) a statement of Your right to bring a civil action under ERISA; and the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
f) the address, telephone number and the electronic address for the Office of Managed Care Ombudsman, listed above.

# 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 INSURANCE COMPANY

# ADDENDUM

# TO

# GROUP POLICY AND CERTIFICATE OF INSURANCE

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

The following language is added to the Group Policy and Certificate of Insurance:

The Company uses Maximum Allowable Charge schedules to determine claim payments. Payment is the lesser of the dentist's submitted charge or the Maximum Allowable Charge.

In-Network Maximum Allowable Charges for Covered Services are determined by geographical area of the dental office. The In-Network Maximum Allowable Charges in the geographical area of the dental office are used to calculate the Company's payment on claims. In-Network Maximum Allowable Charges are reviewed periodically and adjusted as appropriate to reflect increased dentist fees within the geographical areas. Participating Dentists accept their contracted Maximum Allowable Charges as payment in full for Covered Services.

Out-of-Network Maximum Allowable Charges are determined as a percentile of dentist charges for Covered Services by grouping the 90th percentile of dentist charges into different geographical areas. The Out-of-Network Maximum Allowable Charges at the indicated percentile in the geographical area of the dental office are used to calculate the Company's payment on Non-Participating Dentist claims. The source of the dentist charge data is select charge data purchased by the Company supplemented where necessary by internal claim data. Out-of-Network Maximum Allowable Charges are updated periodically.

# Schedule of Benefits

***Concordia Flex sm***

***Group Name: GEOTRANS LLC***
***Group Number(s): 920816000*** ***Effective Date: July 1, 2020***

The grid below provides information related to Covered Services under this Plan. If a service is a Covered Service, a percentage greater than zero in the column titled "Plan Pays" will be indicated. If a Covered Service has a Waiting Period, the Waiting Period will be listed in the column titled "Waiting Period". Some services will be covered in full prior to the Deductible being met. If this is the case, the "Deductible Application" column will indicate "no". If the Deductible must be met prior to a service being covered at the indicated coinsurance, then "yes" will appear in the "Deductible Application column. Only Covered Services are subject to reimbursement. All services on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations. Consult Your Certificate for more details on the services listed. Riders may affect coverage levels. Participating Dentists accept the Maximum Allowable Charge as payment in full.

| Service Category | *Waiting Period* | Plan Pays | Deductible Application |
|---|---|---|---|
| **Diagnostic Services** | | | |
| Oral Evaluations (Exams) | ***None*** | ***100%*** | ***No*** |
| **Radiographs** (X-Rays) | | | |
| Bitewings | ***None*** | ***100%*** | ***No*** |
| Full mouth | ***None*** | ***100%*** | ***No*** |
| **Preventive Services** | | | |
| Prophylaxis (Cleanings) | ***None*** | ***100%*** | ***No*** |
| Topical fluoride | ***None*** | ***100%*** | ***No*** |
| Sealants | ***None*** | ***100%*** | ***No*** |
| Space Maintainers | ***None*** | ***100%*** | ***No*** |
| **Restorative Services** | | | |
| Amalgam Restorations | ***None*** | ***80%*** | ***Yes*** |
| Resin Based Composite –Anterior (White Fillings) | ***None*** | ***80%*** | ***Yes*** |
| Resin Based Composite-Posterior (White Filling) | ***None*** | ***80%*** | ***Yes*** |
| Single Crowns | ***None*** | ***50%*** | ***Yes*** |
| Stainless Steel Crowns | ***None*** | ***80%*** | ***Yes*** |
| Inlays | ***None*** | ***50%*** | ***Yes*** |
| Onlays | ***None*** | ***50%*** | ***Yes*** |
| Inlay Repairs | ***None*** | ***80%*** | ***Yes*** |
| Onlay Repairs | ***None*** | ***80%*** | ***Yes*** |
| Crown Repair | ***None*** | ***80%*** | ***Yes*** |
| **Endodontic Services** | | | |
| Endodontic Therapy (Root canals, etc.) | ***None*** | ***80%*** | ***Yes*** |
| Root Canal Retreatment | ***None*** | ***80%*** | ***Yes*** |

| Service Category | *Waiting Period* | Plan Pays | Deductible Application |
|---|---|---|---|
| Apicoectomy/Periradicular (Root Surgery) | ***None*** | ***80%*** | ***Yes*** |
| **Periodontal Services** | | | |
| Surgical Periodontics | ***None*** | ***80%*** | ***Yes*** |
| Non-Surgical Periodontics | ***None*** | ***80%*** | ***Yes*** |
| Periodontal Maintenance | ***None*** | ***80%*** | ***Yes*** |
| **Prosthodontic Services** | | | |
| Removable Complete and Partial Dentures | ***None*** | ***50%*** | ***Yes*** |
| Adjustments and Repairs of Complete and Partial Dentures | ***None*** | ***80%*** | ***Yes*** |
| **Removal of Teeth** | | | |
| Simple Extractions | ***None*** | ***80%*** | ***Yes*** |
| Surgical Removal | ***None*** | ***80%*** | ***Yes*** |
| **Adjunctive General Services** | | | |
| Consultations | ***None*** | ***100%*** | ***No*** |
| General Anesthesia, Nitrous Oxide and/or IV Sedation | ***None*** | ***80%*** | ***Yes*** |
| Palliative Treatment (Emergency) | ***None*** | ***100%*** | ***No*** |
| **Orthodontic Services** | | | |
| Cosmetic Orthodontic Services | ***None*** | ***0%*** | ***N/A*** |

***Deductibles & Maximums***

- *$50 per calendar year Deductible per Member not to exceed $150 per family*
- *$1,500 per calendar year Maximum per Member*

# SCHEDULE OF EXCLUSIONS AND LIMITATIONS

## THIS PLAN DOES NOT MEET THE MINIMUM ESSENTIAL HEALTH BENEFIT REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE FEDERAL AFFORDABLE CARE ACT.

Exclusions and limitations may differ by state as specified below. Only American Dental Association procedure codes are covered.

**EXCLUSIONS – The following services, supplies or charges are excluded:**

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (for example but not limitation, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).
3. 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 Policies issued and delivered in Georgia, Missouri and Virginia, only services that are the responsibility of Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

   For Group Policies issued and delivered in North Carolina, services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act are excluded only to the extent such services or supplies are the liability of the employee according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

   For Group Policies issued and delivered in Maryland, this exclusion does not apply.
4. For prescription and non-prescription drugs, vitamins or dietary supplements.

   For Group Policies issued and delivered in Arizona and New Mexico, this exclusion does not apply.
5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.

   For Group Policies issued and delivered in Washington, this exclusion does not apply when required dental services and procedures are performed in a dental office for covered persons under the age of seven (7) or physically or developmentally disabled.

   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.
6. Which are Cosmetic in nature as determined by the Company (for example but not limitation, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

   For Group Policies issued and delivered in New Jersey, this exclusion does not apply for Cosmetic services for newly born children of Members.

   For Group Policies issued and delivered in Washington, this exclusion does not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.
7. Elective procedures (for example but not limitation, the prophylactic extraction of third molars).
8. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).

   For Group Policies issued and delivered in Kentucky, Minnesota and Pennsylvania, this exclusion shall not apply to newly born children of Members including newly adoptive children, regardless of age.

   For Group Policies issued and delivered in Colorado, Hawaii, Indiana, Missouri, New Jersey and Virginia, this exclusion shall not apply to newly born children of Members.

   For Group Policies 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 Policies issued and delivered in Washington, this exclusion shall not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.

9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the Schedule of Benefits or a Rider.

10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

    For Group Policies issued and delivered in New York, diagnostic services and treatment of jaw joint problems related to a medical condition are excluded unless specifically covered under the Certificate. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

    For Group Policies issued and delivered in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for treatment of temporomandibular joint disorder (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 the Certificate or the Schedule of Benefits.

    For Group Policies issued and delivered in Minnesota, this exclusion does not apply.

11. For treatment of fractures and dislocations of the jaw.

    For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

12. For treatment of malignancies or neoplasms.

13. Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

15. Preventive restorations.

16. Periodontal splinting of teeth by any method.

17. For duplicate dentures, prosthetic devices or any other duplicative device.

18. For which in the absence of insurance the Member would incur no charge.

19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.

20. 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.

    For Group Policies issued and delivered in Oklahoma, this exclusion does not apply.

21. For treatment and appliances for bruxism (night grinding of teeth).

22. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.

    For Group Policies issued and delivered in Maryland, failure to furnish the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the required time, if the claim is furnished as soon as reasonably possible, and, except in the absence of legal capacity of the Member, not later than one (1) year from the time the claim is otherwise required.

23. Incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).

24. Procedures that are:

    - part of a service but are reported as separate services; or
    - reported in a treatment sequence that is not appropriate; or
    - misreported or that represent a procedure other than the one reported.

25. Specialized procedures and techniques (for example but not limitation, precision attachments, copings and intentional root canal treatment).

26. Fees for broken appointments.

27. Those specifically listed on the Schedule of Benefits as “Not Covered” or “Plan Pays 0%”.
28. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.
29. Orthodontic services, supplies, and appliances.

**LIMITATIONS – Covered services are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the patient reaches any stated age:**

1. Full mouth x-rays - one (1) every 5 year(s).
2. Bitewing x-rays - one (1) set(s) per 12 months under age nineteen (19) and one (1) set(s) per 18 months age nineteen (19) and older.
3. Oral Evaluations:
    - Comprehensive and periodic - two (2) of these services per 12 months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
    - Limited problem focused and consultations - one (1) of these services per dentist per patient per 12 months.
    - Detailed problem focused - one (1) per dentist per patient per 12 months per eligible diagnosis.
4. Prophylaxis - two (2) per 12 months. One (1) additional for Members under the care of a medical professional during pregnancy.
5. Fluoride treatment - one (1) per 12 months under age fourteen (14).
6. Space maintainers - one (1) per five (5) year period for Members under age fourteen (14) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.
7. Sealants - one (1) per tooth per 3 year(s) under age sixteen (16) on permanent first and second molars.
8. Prefabricated stainless steel crowns - one (1) per tooth per lifetime for Members under age fourteen (14).
9. Periodontal Services:
    - Full mouth debridement - one (1) per lifetime.
    - Periodontal maintenance following active periodontal therapy - two (2) per 12 months in addition to routine prophylaxis.
    - Periodontal scaling and root planing - one (1) per 36 months per area of the mouth.
    - Surgical periodontal procedures - one (1) per 36 months per area of the mouth.
    - Guided tissue regeneration - one (1) per tooth per lifetime.
10. Replacement of restorative services only when they are not, and cannot be made, serviceable:
    - Basic restorations - not within 24 months of previous placement of any basic restoration.
    - Single crowns, inlays, onlays - not within 5 year(s) of previous placement of any of the procedures in this category.
    - Buildups and post and cores - not within 5 year(s) of previous placement of any of the procedures in this category.
    - Replacement of natural tooth/teeth in an arch - not within 5 year(s) of a fixed partial denture, full denture or partial removable denture.
11. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every 3 year(s) thereafter.
12. Pulpal therapy - one (1) per primary tooth per lifetime only when there is no permanent tooth to replace it.
13. Root canal retreatment - one (1) per tooth per lifetime.
14. Recementation - one (1) per 3 years. Recementation during the first 12 months following insertion any preventive, restorative or prosthodontic service by the same dentist is included in the preventive, restorative or prosthodontic service benefit.

15. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The 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 under this ABP.
16. Intraoral Films:
    - Periapical - four (4) per 12 months per dentist if not performed in conjunction with definitive procedure(s).
    - Occlusal - two (2) per 24 months under age eight (8).
17. General anesthesia and IV sedation: a total of 60 minutes per session.

# United Concordia Insurance Company

## UCWellness Oral Health Rider

This Rider is effective on the date issued to the Policyholder and is attached to and made a part of the Certificate of Insurance.

**DEFINITIONS**

The following defintion applies when used in this Rider.

**Benefit Period** – The time period specified that applies to each Limitation on the Schedule of Exclusions and Limitations. Benefit Periods shown on the Schedule of Exclusions and Limitations may be expressed in a number of months from the last Covered Service, a calendar year (12 months beginning in January and ending in December), a contract year (12 months beginning with the Effective Date of the Group Policy) or a Member's lifetime.

**ELIGIBILITY**

The additional Benefits in this rider are available to Members that meet at least one of the following criteria, unless other eligibility requirements are specified in the Schedule of Benefits Section of this Rider:

- Member is currently undergoing treatment for the following medical condition(s):
  - Coronary Artery Disease (CAD);
  - Cerebrovascular Disease (CVD);
  - Diabetes;
  - Lupus;
  - Pregnancy;
  - Rheumatoid Arthritis.

**SCHEDULE OF BENEFITS**

**Plan Payment**

In the grouping of dental services called *Exams* on the Schedule of Benefits, the Plan will pay 100% of the Maximum Allowable Charge for periodontal evaluations.

In the grouping of dental services called *Cleanings and Fluoride Treatments* on the Schedule of Benefits, the Plan will pay 100% of the Maximum Allowable Charge for prophylaxis (cleanings).

In the grouping of dental services called *Surgical Periodontics* on the Schedule of Benefits, the Plan will pay 100% of the Maximum Allowable Charge for the following Covered Service(s):

- Gingival flap procedures;
- Osseous surgeries.

In the grouping of dental services called *Non-Surgical Periodontics* on the Schedule of Benefits, the Plan will pay 100% of the Maximum Allowable Charge for the following Covered Service(s):

- Periodontal cleanings;
- Periodontal scaling and root planing.

**Maximums**

The Maximums listed on the Schedule of Benefits do not apply to the following Covered Service(s):

- Exams for all Members;
- Prophylaxis (cleanings) for all Members;
- All X-rays for all Members;
- Fluoride treatments for all Members;
- Sealants for all Members;
- Palliative treatment (emergency treatment of dental pain) for all Members;
- Space maintainers for all Members.

**Applicability of Plan Payments, Deductibles, Maximums and Waiting Periods**

Except where otherwise specifically altered by this Rider, the Plan payments, annual Deductibles, Maximums and Waiting Periods shown on the Schedule of Benefits shall apply to the procedures covered under this Rider.

## SCHEDULE OF EXCLUSIONS AND LIMITATIONS

**Frequency Limitations**

Member's that meet the requirements specified in the Eligibility section of this Rider are entitled to one treatment per Benefit Period in addition to the frequency listed in the Limitations section of the Schedule of Exclusions and Limitations for each of the following Covered Services:

- Periodontal cleanings following active periodontal therapy.

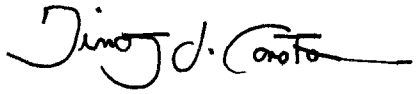
**Applicability of Limitations and Exclusions**

Except where otherwise specifically altered by this Rider, the Limitations and Exclusions listed in the Schedule of Exclusions and Limitations shall apply to the procedures covered under this Rider.

## GENERAL

Except where specifically changed by this Rider, all of the terms and conditions of Your Plan's Certificate of Insurance, Schedule of Benefits and Schedule of Exclusions and Limitations also apply to this Rider. In the event of a conflict between the provisions in this Rider and the Certificate of Insurance, Schedule of Benefits or Schedule of Exclusions and Limitations, this Rider shall control.

UNITED CONCORDIA INSURANCE COMPANY



Authorized Officer