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 Dental Plans of Pennsylvania, Inc.

1800 Center Street, Suite 2B 220
Camp Hill, PA 17011
877-215-3616
www.unitedconcordia.com

Dental Plan
Certificate of Coverage

UNIVERSITY OF PITTSBURGH
GRAD STUDENTS PREMIER
DHMO – January 1, 2024 through August 31, 2024
253212001, 253212011, 253212021, 253212071
253212171

The benefit Plan made available under this Certificate utilizes a preferred provider arrangement.

Services under this Plan must be provided by a Concordia Plus In-Network Dentist as stated under the terms of this Certificate in the Covered Services Section.

United Concordia Dental Plans of Pennsylvania, Inc. 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. Coverage of medically necessary health services is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. United Concordia Dental Plans of Pennsylvania, Inc. 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. United Concordia Dental Plans of Pennsylvania, Inc. 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.

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CERTIFICATE OF COVERAGE

INTRODUCTION

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

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

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

877-215-3616

For general information, In-Network 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 69422
Harrisburg, PA 17106-9422

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TABLE OF CONTENTS

Attached:

Appeal Procedure Addendum
State Law Provisions Addendum, If Applicable
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 – The Health Insurance Marketplace authorized by law or regulation in Pennsylvania 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 Contractholder, has enrolled him/herself and/or his/her eligible Dependents for dental coverage and for whom Premiums are paid. In the case of a Group Contract that covers only dependent children, the Certificate Holder must be the child's or children's parent, stepparent, legal guardian, or legal custodian. Also referred to as "You" or "Your" or "Yourself."

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

Company - The United Concordia Dental Plan indicated on the cover page of this Certificate.

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

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

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

Copayments - Those amounts set forth in the Schedule of Benefits that the Certificate Holder or his/her enrolled Dependents are responsible to pay the treating dentist.

Cosmetic - Those procedures which are undertaken primarily to improve or otherwise modify the Member's appearance when the cause is not related to accidental injury.

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

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

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. The Member shall be held harmless if, after receiving services from a Primary Dentist or Specialty Care Dentist, such services are determined not Dentally Necessary.

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

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

1. The Certificate Holder's spouse, or domestic life partner as defined by the Contractholder and/or state law; and
2. Any unmarried natural child, stepchild, adopted child or child placed with the Certificate Holder or the Certificate Holder's Spouse or domestic partner by order of a court or administrative agency:
   (a) until the end of the month that the child reaches age nineteen (19); 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) when an enrolled full-time student's education is interrupted by military service, until the end of the period beyond the above-stated student age limit, equal to the duration of the enrolled full-time student's service of thirty (30) or more consecutive days on active duty for any reserve component of the United States armed forces or the Pennsylvania National Guard, including State duty or until said enrollee is no longer a full-time student, whichever is sooner; or
   (d) to any age if the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

State Law Provisions Addendum – Attached document, if any, containing specific provisions required by state law to be modified, deleted from, and/or added to the Certificate of Coverage.

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

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

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

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

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

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

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

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

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

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

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

When an enrolled, full-time student's education is interrupted by military service as detailed in the Definition of Dependent of this Certificate, enrollment may be extended beyond the limiting age for full-time students. To qualify for the extension, the Member must submit the required Department of Military

and Veterans Affairs (DMVA) forms to notify Us of placement on active duty, of completion of active duty and of re-enrollment as a full-time student for the first term or semester starting sixty (60) or more days after release from active duty. The DMVA forms are available online at *www.dmva.state.pa.us*.

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;
- 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.

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 Contract.

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 thirty-one (31) day period for newborns or within sixty (60) days from placement for adopted children.

If You have an enrolled Dependent child who is a full-time student at an accredited educational institution, proof of his/her student status and reliance on You for maintenance and support must be furnished to Us within thirty (30) days after he/she attains the limiting age shown in the definition of Dependent. This proof of student status will be requested annually thereafter until the Dependent reaches the limiting age for students and his/her coverage ends.

If You have an enrolled Dependent child who is mentally or physically handicapped, proof of his/her reliance on You for maintenance and support due to his/her condition must be supplied to Us within thirty (30) days after he/she attains the limiting age shown in the definition of Dependent. Such evidence will be requested based on information provided by the Member's physician, but no more frequently than annually.

Dependent coverage may only be terminated when certain life change events occur including death, divorce or dissolution of the union or domestic partnership, reaching the limiting age or during open enrollment periods.

Late Enrollment

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

HOW THE DENTAL PLAN WORKS

Entire Contract

This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses

After three years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred or disability (as defined in the Policy) commencing after the expiration of such three year period.

No claim for loss incurred or disability (as defined in the Policy) commencing after three years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

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 Member to the Company, located at 1800 Center Street, Suite 2B 220, Camp Hill, PA 17011, or to any authorized agent of the Company, with information sufficient to identify the Member, shall be deemed notice to the Company.

Claim Forms

The Company, upon receipt of a notice of claim, will furnish to the Member such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after the Company 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, written proof covering the occurrence, character, and extent of the loss for which claim is made.

The Company will provide claim forms to and accept claims for filing proof of loss submitted by a custodial parent of an eligible Dependent child who is the subject of a court or administrative order relating to provision of health care coverage. If services are provided by a Non-Participating Dentist, the Company will make payments directly to such custodial parent or to the Department of Public Welfare if benefits are payable under Medical Assistance.

Proof of Loss

Written proof of loss must be furnished to the Company at its said office in case of claim for loss for which this Policy provides any periodic payment (to be paid not less than monthly) contingent upon continuing loss within ninety (90) days after the termination of the period for which the Company is liable and in case of claim for any other loss within ninety (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 (1) year from the time proof is otherwise required.

The acknowledgment by the Company of the receipt of notice given or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the Company in defense of any claim arising under such policy.

Time Payment of Claims

All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid no later than thirty (30) days from receipt of due written proof of such loss. The Company may extend this thirty-day period by no more than fifteen (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 policy 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.

Payment of Claims

All benefits under this policy shall be payable to the Participating Dentist or the Member, or to his designated beneficiary or beneficiaries, or to his estate, except that if the Member be a minor or otherwise not competent to give a valid release, such benefits may be made payable to his custodial parent, guardian, or other person actually supporting him. All or a portion of any indemnities provided by this Policy on account of dental services may, at the option of the Company and unless the Member requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the dental office rendering such services.

Physical Examinations

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 hereunder.

Legal Actions

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty (60) days after written proof of loss has been filed in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Change of Beneficiary

Unless the Member makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Member and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Policy or to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

Choice of Provider at Enrollment

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

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

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

Changing Primary Dental Offices

You or Your Dependents may request to change Primary Dental Offices at any time. Simply call our Customer Service center toll-free at the number in the Introduction section of this Certificate or visit Our

website. You will be informed of the effective date of Your transfer, and the newly selected office will also be notified. You must request the transfer prior to seeking services from the new Primary Dental Office. Any dental procedures in progress must be completed before the transfer.

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

Coordination of Care and Referrals

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

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

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

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

Dental Emergencies

If You have a Dental Emergency, You should contact Your Primary Dental Office or go to a conveniently located general Dentist. Ask the dental office to call Our Customer Service Unit to verify coverage. Obtain an itemized bill from the dental office to submit to Us. The Plan will cover certain diagnostic and therapeutic procedures in accordance with the Schedule of Benefits and the Schedule of Exclusions and Limitations. Your cost will be limited to any applicable Copayment on the Schedule of Benefits. You must return to Your Primary Dental Office for any necessary follow-up care.

Out-of-Network Care

In the event that a Specialty Care Dentist is not available within a thirty (30) mile radius of Your home, We may arrange treatment by an Out-of-Network Dentist. Call Our Customer Service unit at the telephone number listed in the Introduction section of this Certificate. The unit will arrange a visit to an Out-of-Network Dentist. Your cost will be limited to the Copayment listed on the Schedule of Benefits as long as the dental procedure is covered under the Plan.

BENEFITS

Covered Services

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

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

Exclusions

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

Copayments and Other Charges

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

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

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

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

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

Payment of Benefits

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

Coordination of Benefits (COB)

If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, benefits will be coordinated. This means that one plan will be primary and

determine its benefits before those of the other plan and without considering the other plan's benefits. The other plan will be secondary and determine its benefits after the primary plan. The secondary plan's benefits may be reduced because of the primary plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this Plan will determine payment.

1. The following words and phrases regarding the Coordination of Benefits ("COB") provision are defined as set forth below:

   A) **Allowable Amount** is the 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 type hospital indemnity benefits of $100 per day or less.
   D) **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.
   E) **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.
   F) **Plan** means this document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.

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

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

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

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

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

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

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

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

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

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

Workers' Compensation

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

Review of a Benefit Determination

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

TERMINATION -- WHEN COVERAGE ENDS

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

- on the date You no longer meet Your Group's eligibility requirements; or
- on the date Premium payment ceases for You; or
- on the date Your Dependent(s) cease to meet the requirements in the definition of Dependent in the Definitions section of this Certificate;

- on the date You no longer meet other eligibility requirements imposed by an Authorized Entity; or
- on the termination date specified for You by an Authorized Entity; or
- on the postmark date of the notice We provide to You regarding a final disposition of a fraud conviction for the Certificate Holder or his/her Dependents; or
- on the date the Certificate Holder's residence changes to an area outside the State of Pennsylvania.

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 a State Law Provisions Addendum to this Certificate. If the Group Contract is cancelled, Certificate Holder and Dependent coverage will end on the Group Contract Termination Date.

Grace Period: The Company may terminate the Group Contract upon default in the payment of Premium by giving to the Contractholder thirty-one (31) days prior written notice of such termination or nonrenewal. Notice to the Contractholder shall state the amount of Premium due and the Grace Period for payment. Payment of said sum prior to the date of intended termination shall continue this Group Contract in full force and effect. If payment is not remitted by the end of the Grace Period, the Group Contract will terminate and coverage will end on the first day following the expiration of the Grace Period. During the Grace Period, coverage shall continue in effect regardless of non-payment of Premium.

Reinstatement: If any renewal Premium is not paid within the time granted the Group for payment, a subsequent acceptance of Premium by the Company or by any agent duly authorized by the Company to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy. However, if the Company requires an application for reinstatement and issues a conditional receipt for the Premium, the Policy will be reinstated upon approval of such application by the Company. Lacking such approval, the Policy will be reinstated upon the forty-fifth day following the date of such conditional receipt unless the Company has previously notified the Policyholder in writing of its disapproval of such application. The Policyholder and Company shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

We are not liable to pay any benefits for services that are started after the Termination Date. However, coverage for completion of a dental procedure requiring two (2) or more visits on separate days will be extended for a period of ninety (90) days after the Termination Date in order for the procedure to be finished. The procedure must be started prior to the Termination Date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Termination Date.

CONTINUATION COVERAGE

Federal or state law may require that certain employers offer continuation coverage to Members for a specified 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 this requirement does apply, You must elect to continue coverage within sixty (60) days from Your qualifying event or notification of rights by Your Group, whichever is later. Dependents may have separate election rights, or You may elect to continue coverage for them. You must pay the required premium for continuation coverage directly to Your Group. The Company is not responsible for determining who is eligible for continuation coverage.

GENERAL PROVISIONS

This Certificate includes and incorporates any and all riders, endorsements, addenda, and schedules and together with the Group Contract represents the entire agreement between the parties with respect to the

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

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 Pennsylvania.

Privacy and Confidentiality of Dental Records

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

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

ADDENDUM TO CERTIFICATE

APPEAL PROCEDURE

This Addendum is effective on the Effective Date stated in the Group Contract. 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 benefit determination" is a denial, reduction, or termination of or failure to make payment (in whole or in part) based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is Experimental or Investigational or not Dentally Necessary or appropriate.

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

"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.

PROCEDURE

You or Your authorized representative may file an appeal with Us within 180 days of receipt of an adverse benefit determination. To file an appeal, telephone the toll-free number listed on Your ID card.

We will review the claim and notify You of Our decision within 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 benefit determination.

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 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;
d) a statement of Your right to bring a civil action under ERISA; and
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."

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 dental℠

Concordia Plus
Schedule of Benefits
Plan University of Pittsburgh Grad Students

IMPORTANT INFORMATION ABOUT YOUR PLAN **January 1, 2024**

- This schedule of benefits provides a listing of procedures covered by your plan. For procedures that require a copayment, the amount to be paid is shown in the column titled "Member Pays $." You pay these copayments to the dental office at the time of service.
- You must select a United Concordia Primary Dental Office (PDO) to receive covered services. Your PDO will perform the below procedures or refer you to a specialty care dentist for further care. Treatment by an Out-of-Network dentist is not covered, except as described in the Certificate of Coverage.
- Only procedures listed on this Schedule of Benefits are Covered Services. For services not listed (not covered), You are responsible for the full fee charged by the dentist. Procedure codes and member Copayments may be updated to meet American Dental Association (ADA) Current Dental Terminology (CDT) in accordance with national standards.
- For a complete description of your plan, please refer to the Certificate of Coverage and the Schedule of Exclusions and Limitations in addition to this Schedule of Benefits.
- If you have questions about your United Concordia Dental Plan, please call our Customer Service Department toll free at 1-877-215-3616 or access our website at www.unitedconcordia.com.

ADA Code	ADA Description	Member Pays $
	CLINICAL ORAL EVALUATIONS	
D0120	Periodic Oral Evaluation - Established Patient	0
D0140	Limited Oral Evaluation - Problem Focused	0
D0145	Oral Evaluation For A Patient Under 3 Years Of Age And Counseling With Primary Caregiver	0
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	0
D0170	Re-Evaluation-Limited, Problem Focused (Established Patient; Not Post-Operative Visit)	0
D0171	Re-Evaluation - Post-Operative Office Visit	0
D0180	Comprehensive Periodontal Evaluation	0
	RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)	
D0210	Intraoral - Comprehensive Series Of Radiographic Images	0
D0220	Intraoral- Periapical First Radiographic Image	0
D0230	Intraoral- Periapical Each Additional Radiographic Image	0
D0240	Intraoral - Occlusal Radiographic Image	0
D0270	Bitewing - Single Radiographic Image	0
D0272	Bitewings - Two Radiographic Images	0
D0273	Bitewings - Three Radiographic Images	0
D0274	Bitewings - Four Radiographic Images	0
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	0
D0330	Panoramic Radiographic Image	0

ADA Code	ADA Description	Member Pays $
	RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)	
D0340	2D Cephalometric Radiographic Image - Acquisition, Measurement And Analysis	0
D0372	Intraoral Tomosynthesis - Comprehensive Series of Radiographic Images	0
D0373	Intraoral Tomosynthesis – Bitewing Radiographic Image	0
D0374	Splint – Extra-Coronal; Natural Teeth or Prosthetic Crowns	0
	TESTS AND EXAMINATIONS	
D0396	3D Printing of a 3D Dental Surface Scan	0
D0460	Pulp Vitality Tests	0
D0470	Diagnostic Casts	0
	ORAL PATHOLOGY LABORATORY	
D0601	Caries Risk Assessment And Documentation, With A Finding Of Low Risk	0
D0602	Caries Risk Assessment And Documentation, With A Finding Of Moderate Risk	0
D0603	Caries Risk Assessment And Documentation, With A Finding Of High Risk	0
	DENTAL PROPHYLAXIS	
D1110	Prophylaxis, Adult	0
D1120	Prophylaxis, Child	0
	TOPICAL FLUORIDE TREATMENT (office procedure)	
D1206	Topical Application Of Fluoride Varnish	0
D1208	Topical Application Of Flouride - Excluding Varnish	0
	OTHER PREVENTIVE SERVICES	

ADA Code	ADA Description	Member Pays $	
	OTHER PREVENTIVE SERVICES		
D1301	Immunization Counseling	0	
D1330	Oral Hygiene Instruction	0	
D1351	Sealant - Per Tooth	8	
D1353	Sealant Repair - Per Tooth	8	
D1354	Application of Caries Arresting Medicament - Per Tooth	15	
D1355	Caries preventive medicament application - per tooth	15	
	SPACE MAINTENANCE (passive appliances)		
D1510	Space maintainer - fixed, unilateral - per quadrant	42	
D1516	Space Maintainer - Fixed - bilateral, maxillary	64	
D1517	Space Maintainer - Fixed - bilateral, mandibular	64	
D1520	Space maintainer - removable, unilateral - per quadrant	55	
D1526	Space Maintainer - Removable - bilateral, maxillary	72	
D1527	Space Maintainer - Removable - bilateral, mandibular	72	
D1556	Removal of fixed unilateral space maintainer - per quadrant	0	
D1557	Removal of fixed unilateral space maintainer - maxillary	0	
D1558	Removal of fixed unilateral space maintainer - mandibular	0	
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	42	
	AMALGAM RESTORATIONS (including polishing)		
D2140	Amalgam - One Surface, Primary Or Permanent	13	
D2150	Amalgam - Two Surfaces, Primary Or Permanent	17	
D2160	Amalgam - Three Surfaces, Primary Or Permanent	19	
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	23	
	RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
D2330	Resin-Based Composite - One Surface, Anterior	15	
D2331	Resin-Based Composite - Two Surfaces, Anterior	20	
D2332	Resin-Based Composite - Three Surfaces, Anterior	23	
D2335	Resin-Based Composite - Four Or More Surfaces (Anterior)	25	
D2391	Resin-Based Composite - One Surface, Posterior	45	
D2392	Resin-Based Composite - Two Surfaces, Posterior	55	
D2393	Resin-Based Composite - Three Surfaces, Posterior	65	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	80	
	INLAY/ONLAY RESTORATIONS		
D2510	Inlay - Metallic - One Surface	236	◆
D2520	Inlay - Metallic - Two Surfaces	254	◆
D2530	Inlay - Metallic - Three Or More Surfaces	279	◆
D2542	Onlay - Metallic-Two Surfaces	322	◆
D2543	Onlay - Metallic - Three Surfaces	342	◆
D2544	Onlay - Metallic - Four Or More Surfaces	361	◆
	CROWNS - SINGLE RESTORATIONS ONLY		
D2710	Crown-Resin-Based Composite (Indirect)	117	
D2712	Crown - 3/4 Resin-Based Composite (Indirect)	128	
D2740	Crown, Porcelain/Ceramic	341	
D2750	Crown, Porcelain Fused To High Noble Metal	329	◆
D2751	Crown-Porcelain Fused To Predominantly Base Metal	294	
D2752	Crown, Porcelain Fused To Noble Metal	316	◆
D2753	Crown - porcelain fused to titanium and titanium alloys	316	
D2780	Crown - 3/4 Cast High Noble Metal	337	◆
D2781	Crown - 3/4 Cast Predominantly Base Metal	337	
D2782	Crown - 3/4 Cast Noble Metal	337	◆
D2783	Crown - 3/4 Porcelain/Ceramic	337	
D2790	Crown, Full Cast High Noble Metal	321	◆
D2791	Crown - Full Cast Predominantly Base Metal	293	
D2792	Crown, Full Cast Noble Metal	304	◆
D2794	Crown - titanium and titanium alloys	294	
D2799	Interim Crown - Further Treatment Or Completion Of Diagnosis Necessary Prior To Final Impression	26	
	OTHER RESTORATIVE SERVICES		
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	11	
D2915	Re-Cement Or Rebond Indirectly Fabricated Or Prefabricated Post And Core	11	
D2920	Re-Cement Or Re-Bond Crown	11	
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	30	
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	32	
D2940	Protective Restoration	0	
D2949	Restorative Foundation For An Indirect Restoration	0	
D2950	Core Buildup Including Any Pins When Required	36	
D2951	Pin Retention - Per Tooth, In Addition To Restoration	12	
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	92	
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	50	
D2954	Prefabricated Post And Core In Addition To Crown	42	
D2957	Each Additional Prefabricated Post - Same Tooth	25	
D2971	Additional Procedures To Customize a Crown to fit Under an Existing Partial Denture Framework	25	

ADA Code	ADA Description	Member Pays $
	OTHER RESTORATIVE SERVICES	
D2991	Application of Hydroxyapatite Regeneration Medicament – per tooth	45
	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)	17
D3221	Pulpal Debridement, Primary And Permanent Teeth	16
D3222	Partial Pulpotomy For Apexogenesis-Permanent Tooth With Incomplete Root Development	17
	ENDODONTIC THERAPY ON PRIMARY TEETH	
D3230	Pulpal Therapy (Resorbable Filling)-Anterior, Primary Tooth (Excluding Final Restoration)	26
D3240	Pulpal Therapy (Resorbable Filling)-Posterior, Primary Tooth (Excluding Final Restoration)	32
	ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	75
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	90
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)	178
	ENDODONTIC RETREATMENT	
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	69
D3347	Retreatment Or Previous Root Canal Therapy - Premolar	118
D3348	Retreatment Of Previous Root Canal Therapy - Molar	284
	APICOECTOMY/PERIRADICULAR SERVICES	
D3410	Apicoectomy - Anterior	114
D3421	Apicoectomy - Premolar (First Root)	183
D3425	Apicoectomy - Molar (First Root)	196
D3426	Apicoectomy (Each Additional Root)	69
D3450	Root Amputation - Per Root	101
D3471	Surgical repair of root resorption – anterior	196
D3472	Surgical repair of root resorption – premolar	196
D3473	Surgical repair of root resorption – molar	196
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	196
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	196
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	196
	OTHER ENDODONTIC PROCEDURES	

ADA Code	ADA Description	Member Pays $
	OTHER ENDODONTIC PROCEDURES	
D3920	Hemisection (Including Any Root Removal) Not Including Root Canal Therapy	84
D3921	Decoronation or submergence of an erupted tooth	51
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	82
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	37
D4212	Gingivectomy Or Gingivoplasty To Allow Access For Restorative Procedure, Per Tooth	0
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	105
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	47
D4245	Apically Positioned Flap	138
D4249	Clinical Crown Lengthening-Hard Tissue	168
D4260	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	205
D4261	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	87
D4274	Mesial/Distal Wedge Procedure, Single Tooth (When Not Performed In Conjunction With Surgical Procedures In The Same Anatomical Area)	119
D4286	Removal of Non-Resorbable Barrier	0
	NON-SURGICAL PERIODONTAL SERVICES	
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	40
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	17
D4346	Scaling In Presence Of Generalized Moderate Or Severe Gingival Inflammation - Full Mouth, After Oral Evaluation	32
D4355	Full Mouth Debridement To Enable a Comprehensive Periodontal Evaluation And Diagnosis on a Subsequent Visit	22
D4381	Localized Delivery Of Antimicrobial Agents Via Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth	100
	OTHER PERIODONTAL SERVICES	
D4910	Periodontal Maintenance	32

ADA Code	ADA Description	Member Pays $
	OTHER PERIODONTAL SERVICES	
D4921	Gingival Irrigation with a medicinal agent - Per Quadrant	25
	COMPLETE DENTURES (including routine post delivery care)	
D5110	Complete Denture - Maxillary	343
D5120	Complete Denture - Mandibular	343
D5130	Immediate Denture - Maxillary	359
D5140	Immediate Denture - Mandibular	359
	PARTIAL DENTURES (including routine post-delivery care)	
D5211	Maxillary Partial Denture - Resin Base (Including Retentive/Clasping Materials, Rests And Teeth)	284
D5212	Mandibular Partial Denture - Resin Base (Including Retentive/Clasping Materials, Rests And Teeth)	335
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	377
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	377
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	284
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	335
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	377
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	377
D5225	Maxillary Partial Denture - Flexible Base (Including Retentive/Clasping materials, Rests And Teeth)	433
D5226	Mandibular Partial Denture - Flexible Base (Including Retentive/Clasping materials, Rests And Teeth)	433
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	284
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	335
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary	232
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular	232
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests and teeth) - per quadrant	232

ADA Code	ADA Description	Member Pays $
	PARTIAL DENTURES (including routine post-delivery care)	
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests and teeth) - per quadrant	232
	ADJUSTMENTS TO DENTURES	
D5410	Adjust Complete Denture - Maxillary	10
D5411	Adjust Complete Denture - Mandibular	10
D5421	Adjust Partial Denture - Maxillary	11
D5422	Adjust Partial Denture - Mandibular	11
	REPAIRS TO COMPLETE DENTURES	
D5511	Repair Broken Complete Denture Base, Mandibular	19
D5512	Repair Broken Complete Denture Base, Maxillary	19
D5520	Replace Missing Or Broken Teeth-Complete Denture (Each Tooth)	17
	REPAIRS TO PARTIAL DENTURES	
D5611	Repair Resin Partial Denture Base, Mandibular	19
D5612	Repair Resin Partial Denture Base, Maxillary	19
D5621	Repair Cast Partial Framework, Mandibular	20
D5622	Repair Cast Partial Framework, Maxillary	20
D5630	Repair Or Replace Broken Retentive Clasping Materials - Per Tooth	23
D5640	Replace Broken Teeth-Per Tooth	17
D5650	Add Tooth To Existing Partial Denture	20
D5660	Add Clasp To Existing Partial Denture - Per Tooth	24
D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)	242
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	242
	DENTURE REBASE PROCEDURES	
D5710	Rebase Complete Maxillary Denture	60
D5711	Rebase Complete Mandibular Denture	60
D5720	Rebase Maxillary Partial Denture	58
D5721	Rebase Mandibular Partial Denture	58
D5725	Rebase hybrid prosthesis	58
	DENTURE RELINE PROCEDURES	
D5730	Reline Complete Maxillary Denture (direct)	36
D5731	Reline Complete Mandibular Denture (direct)	36
D5740	Reline Maxillary Partial Denture (direct)	33
D5741	Reline Mandibular Partial Denture (direct)	33
D5750	Reline Complete Maxillary Denture (indirect)	51
D5751	Reline Complete Mandibular Denture (indirect)	51
D5760	Reline Maxillary Partial Denture (indirect)	49
D5761	Reline Mandibular Partial Denture (indirect)	48

ADA Code	ADA Description	Member Pays $	
	DENTURE RELINE PROCEDURES		
D5765	Soft liner for complete or partial removable denture – indirect	36	
	OTHER REMOVABLE PROSTHETIC SERVICES		
D5850	Tissue Conditioning, Maxillary	33	
D5851	Tissue Conditioning, Mandibular	33	
D5863	Overdenture - Complete Maxillary	343	
D5864	Overdenture - Partial Maxillary	377	
D5865	Overdenture - Complete Mandibular	343	
D5866	Overdenture - Partial Mandibular	377	
	FIXED PARTIAL DENTURE PONTICS		
D6205	Pontic - Indirect Resin Based Composite	290	
D6210	Pontic-Cast High Noble Metal	325	◆
D6211	Pontic-Cast Predominatly Base Metal	298	
D6212	Pontic-Cast Noble Metal	312	◆
D6214	Pontic - titanium and titanium alloys	299	
D6240	Pontic-Porcelain Fused To High Noble Metal	327	◆
D6241	Pontic-Porcelain Fused To Predominantly Base Metal	289	
D6242	Pontic-Porcelain Fused To Noble Metal	315	◆
D6243	Pontic - porcelain fused to titanium and titanium alloys	315	
D6245	Pontic - Procelain/Ceramic	290	
	FIXED PARTIAL DENTURE RETAINTERS - INLAYS/ONLAYS		
D6610	Retainer Onlay - Cast High Noble Metal, Two Surfaces	322	◆
D6612	Retainer Onlay - Cast Predominantly Base Metal, Two Surfaces	322	
D6614	Retainer Onlay - Cast Noble Metal, Two Surfaces	322	◆
	FIXED PARTIAL DENTURE RETAINERS - CROWNS		
D6710	Retainer Crown - Indirect Resin Based Composite	295	
D6740	Retainer Crown - Porcelain/Ceramic	295	
D6750	Retainer Crown, Porcelain Fused To High Noble Metal	329	◆
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	294	
D6752	Retainer Crown, Porcelain Fused To Noble Metal	316	◆
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	316	
D6780	Retainer Crown, 3/4 Cast High Noble Metal	321	◆
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	321	
D6782	Retainer Crown - 3/4 Cast Noble Metal	321	◆
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	321	
D6784	Retainer crown 3/4 - titanium and titanium alloys	321	
D6790	Retainer Crown, Full Cast High Noble Metal	327	◆
D6791	Retainer Crown, Full Cast Predominantly Base Metal	292	
D6792	Retainer Crown, Full Cast Noble Metal	319	◆

ADA Code	ADA Description	Member Pays $
	FIXED PARTIAL DENTURE RETAINERS - CROWNS	
D6794	Retainer crown - titanium and titanium alloys	292
	OTHER FIXED PARTIAL DENTURE SERVICES	
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	30
	EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)	
D7111	Extraction, Coronal Remnants - Primary Tooth	10
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	16
	SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)	
D7210	Extraction, Erupted Tooth Requiring Removal Of Bone And/Or Sectioning Of Tooth, And Including Elevation Of Mucoperiosteal Flap If Indicated	51
D7220	Removal Of Impacted Tooth - Soft Tissue	72
D7230	Removal Of Impacted Tooth - Partially Bony	98
D7240	Removal Of Impacted Tooth - Completely Bony	113
D7241	Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	120
D7250	Removal Of Residual Tooth Roots (Cutting Procedure)	53
D7251	Coronectomy-Intentional Partial Tooth Removal, impacted teeth only	113
	OTHER SURGICAL PROCEDURES	
D7280	Exposure Of An Unerupted Tooth	97
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	26
D7284	Excisional biopsy of minor salivary glands	245
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	48
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	60
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth Or Tooth Spaces, Per Quadrant	25
	SURGICAL INCISION	
D7509	Marsupialization of Odontogenic Cyst	245
	OTHER REPAIR PROCEDURES	
D7961	Buccal / labial frenectomy (frenulectomy)	89
D7962	Lingual frenectomy (frenulectomy)	89
D7963	Frenuloplasty	44
	LIMITED ORTHODONTIC TREATMENT	
D8010	Limited Orthodontic Treatment Of Primary Dentition	599
D8020	Limited Orthodontic Treatment Of Transitional Dentition	759

ADA Code	ADA Description	Member Pays $
	LIMITED ORTHODONTIC TREATMENT	
D8030	Limited Orthodontic Treatment Of Adolescent Dentition	1071
D8040	Limited Orthodontic Treatment Of The Adult Dentition	927
	COMPREHENSIVE ORTHODONTIC TREATMENT	
D8070	Comprehensive Orthodontic Treatment Of Transitional Dentition	3190
D8080	Comprehensive Orthodontic Treatment Of Adolescent Dentition	3454
D8090	Comprehensive Orthodontic Treatment Of Adult Dentition	3540
	MINOR TREATMENT TO CONTROL HARMFUL HABITS	
D8210	Removable Appliance Therapy For Control Of Harmful Habits	433
D8220	Fixed Appliance Therapy For Control Of Harmful Habits	537
	OTHER ORTHODONTIC SERVICES	
D8680	Orthodontic Retention (Removal Of Appliances, Construction And Placement Of Retainer(S)	343
	UNCLASSIFIED TREATMENT	
D9110	Palliative Treatment Of Dental Pain - per visit	0
	PROFESSIONAL CONSULTATION	
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician Other Than Requesting Dentist Or Physician	19
D9311	Consultation With A Medical Health Care Professional	0
	PROFESSIONAL VISITS	
D9430	Office Visit For Observation (During Regularly Scheduled Hours) - No Other Services Performed	0
	MISCELLANEOUS SERVICES	
D9932	Cleaning And Inspection Of Removable Complete Denture, Maxillary	0
D9933	Cleaning And Inspection Of Removable Complete Denture, Mandibular	0
D9934	Cleaning And Inspection Of Removable Partial Denture, Maxillary	0
D9935	Cleaning And Inspection Of Removable Partial Denture, Mandibular	0
D9986	Missed Appointment	15
D9987	Cancelled appointment	15
D9990	Certified translation or sign-language services - per visit	0
D9991	Dental Case Management - Addressing Appointment Compliance Barriers	0
D9992	Dental Case Management - Care Coordination	0
D9993	Dental Case Management - Motivational Interviewing	0
D9994	Dental Case Management - Patient Education To Improve Oral Health Literacy	0
D9995	Teledentistry - Synchronous; Real-Time Encounter	0
D9996	Teledentistry - Asynchronous; Information Stored and Forwarded to Dentist for Subsequent Review	0
D9997	Dental care management - patients with special health care needs	0

FOOTNOTES

◆ Charges for the use of precious (high noble) or semi precious (noble) metal are not included in the copayment for crowns, bridges, pontics, inlays and onlays. The decision to use these materials is a cooperative effort between the provider and the patient, based on the professional advice of the provider. Providers are expected to charge no more than an additional $125 for these materials.

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.