Effective Plan Year 2024

Pediatric Dental Certificate of Insurance

UPMC Dental *Advantage
UPMC HEALTH BENEFITS, INC. (hereafter referred to as "UPMC Health Plan"[1] or "the Plan")
a Pennsylvania corporation whose address is
U.S. Steel Tower, 600 Grant Street, Pittsburgh, PA 15219

STUDENT GUARANTEED RENEWABLE/PREMIUM SUBJECT TO CHANGE

Welcome and General Information for Members

This document is your Pediatric Dental Certificate of Insurance ("Certificate") for your Preferred Provider Organization (PPO) dental plan. If this Certificate has been purchased on behalf of a child, references to "you" or "your" should be considered to reference the child. Your Certificate establishes the terms of coverage for your dental plan. It sets forth what services are covered and what services are not covered. It explains the procedures that you must follow to ensure that the dental services you receive will be covered under your benefit plan. It also describes how you can submit a claim, file a Complaint or appeal an Adverse Benefit Determination, and other information that you may need to know to access your dental benefits. The Certificate acts as a contract between you and the Plan, setting forth your obligations as a Member and our obligations as your dental plan.

It is important to use this Certificate along with your Pediatric Dental Schedule of Benefits. Your Pediatric Dental Schedule of Benefits is the document that outlines your coverage amount. Anything contained herein to the contrary notwithstanding, the Plan shall have the right, for the purpose of complying with the provisions of any law or any lawful order of a regulatory authority, to amend the Certificate or any attachment hereto or to increase, reduce, or eliminate any of the benefits provided in the Certificate for any one or more eligible Members enrolled under the Certificate, and each party hereby agrees to any amendment of the Certificate which is necessary in order to accomplish such purpose.

The dental coverage described in this document is deemed an Essential Health Benefit (EHB) for Members up to the age of 19 who are enrolled in medical coverage and applies only to those Members who meet this criterion.

This Certificate does not divide or give back any excess premiums to its Members.

This PPO plan may not cover all your dental expenses. Read this Certificate carefully to determine which dental services are covered.

You have the right to return this Certificate within 10 days of its delivery and to have the premium rate refunded if, after examination of the Certificate, you are not satisfied for any reason.

[1]UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC for You Inc. Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

Guaranteed renewable/Premium subject to change
UPMC Health Plan may adjust premiums after getting approval from the Pennsylvania Insurance Department. You will be notified in advance of any change in your premium. This Certificate will remain in effect each month as long as the applicable premiums are paid. UPMC Health Plan will not terminate your coverage because of the deterioration of your mental or physical health or that of any individual covered under this Certificate. This Certificate shall remain in effect continually unless terminated by UPMC Health Plan in accordance with the termination section under your medical Policy, you elect to disenroll in coverage, you fail to meet the eligibility requirements as determined by your school or university, or your school or university no longer contracts for coverage.

Health Care Concierge team
To help you get accurate answers to questions and up-to-date information about your dental program, please log in to *My*Health OnLine via **www.upmchealthplan.com,** call 1-877-648-9640 (TTY:711), or write to UPMC Health Plan, U.S. Steel Tower, 600 Grant Street, Pittsburgh, PA 15219. You can:

- Learn about UPMC Dental *Advantage.*
- Find Participating Dentists.
- Verify your eligibility.
- Request an Out-of-Network Care Claim Form.
- Speak with our Health Care Concierge team.
- Ask any questions about your dental care benefits.
- Initiate a Complaint regarding a Participating Dentist or your coverage (including Certificate exclusions and noncovered benefits).
- Initiate an appeal of an Adverse Benefit Determination based on the Dental/Medical Necessity and appropriateness of a dental service.

Our Health Care Concierge team is available Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m. at **1-877-648-9640**. Members who use a TTY (teletypewriter) may access TTY services by calling TTY: **711.**

*UPMC Dental *Advantage* is a product of UPMC Health Benefits Inc. and is administered by SKYGEN. Please note that throughout this document, we use the terms "UPMC Health Plan" and "the Plan" to refer to UPMC Health Benefits Inc. as well as to UPMC Health Plan Inc.

Diane P. Holder, President and CEO, UPMC Health Benefits Inc.

Gordon Gebbens, Chief Financial Officer, UPMC Health Benefits Inc.

TABLE OF CONTENTS

Terms and Definitions to Help You Understand Your Coverage

The following are some important, frequently used terms and definitions that the Plan uses in this Certificate and when administering your benefits.

Adverse Benefit Determination –Any of the following:

- A determination by UPMC Health Plan that a request for a benefit does not meet UPMC Health Plan's requirements for Dental/Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental/Investigational, such that the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit.
- UPMC Health Plan's denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination that you are ineligible for coverage, failed to submit complete information, or failed to comply with an administrative policy of UPMC Health Plan (Administrative Denials).
- A rescission of coverage determination by UPMC Health Plan (retroactive cancellation of your coverage due to fraud or intentional misrepresentation of a material fact).

Instructions regarding how to appeal an Adverse Benefit Determination are set forth in **Section VIII.** Resolving Disputes with UPMC Health Plan.

Appeal – A request for your Plan to review an Adverse Benefit Determination.

Benefit Limit – The maximum amount that the Plan will pay for a Covered Service. Some Benefit Limits are discussed in this Certificate, but generally are set forth in your Pediatric Dental Schedule of Benefits.

Benefit Period – The specified period of time (for which you are eligible for coverage during your university/school's contract year) during which charges for Covered Services must be incurred in order to be eligible for payment by UPMC Health Plan. A charge shall be considered incurred on the date you receive the service or supply.

Coinsurance – The percentage of expenses for Covered Benefits that you are responsible to pay, after meeting your Deductible, if you have one. The amount of your Coinsurance depends upon the plan you are enrolled in. Refer to your Pediatric Dental Schedule of Benefits to determine Coinsurance amounts. Copayments do not apply toward Coinsurance.

Complaint – A dispute or objection by you regarding a Participating Dentist or the coverage (including contract exclusions and noncovered benefits), operations, or management policies of this dental plan. Instructions on how to file a Complaint are set forth in the **Resolving Disputes with the Plan** section of this Certificate.

Covered Benefit or Covered Service – A service or supply that meets the requirements set forth in this Certificate.

Deductible(s) – The initial amount that you must pay each year for Covered Benefits before the Plan begins to pay for Covered Benefits. See your Pediatric Dental Schedule of Benefits to determine which services, if any, apply to the Deductible and the Deductible amounts.

Dental Emergency – Unless specifically otherwise defined by federal or state law or regulation, means a dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) or for which dental attention is required for the prevention of immediate damage to dentition.

Dentally Necessary or Dental Necessity – Unless otherwise defined in a federal or state law or regulation means those Covered Services that are determined by the Plan to be

A. commonly recognized throughout the dentist's specialty as appropriate for the diagnosis and/or treatment of the Member's condition, illness, disease, or injury;

B. provided in accordance with standards of good dental practice and consistent with scientifically based guidelines of dental organizations, research, or health care coverage organizations or governmental agencies that are accepted by the Plan;
C. reasonably expected to improve an individual's condition or level of functioning;
D. in conformity, at the time of treatment, with criteria/guidelines adopted by the Plan or its designee;
E. provided not only as a convenience or comfort measure or to improve physical appearance; and
F. rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service.

The Plan reserves the right to determine in its sole judgment whether a service is Dentally Necessary and appropriate. Note that, for purposes of coverage, the fact that a dentist orders, prescribes, recommends, or approves a dental service does not mean that the service is a Covered Service.

Final Adverse Benefit Determination — A decision by UPMC Health Plan to partially or fully uphold an Adverse Benefit Determination following completion of UPMC Health Plan's internal appeal process.

Medical Necessity or Medically Necessary – Health care services covered under your benefit plan that are determined by UPMC Health Plan to be:

- Commonly recognized throughout the provider's specialty as appropriate for the diagnosis and/or treatment of the Member's condition, illness, disease, or injury.
- Provided in accordance with standards of good medical practice and consistent with scientifically based guidelines of medical, research, or health care coverage organizations or governmental agencies that are accepted by UPMC Health Plan.
- Reasonably expected to improve an individual's condition or level of functioning; and in conformity, at the time of treatment, with medical management criteria/guidelines adopted by UPMC Health Plan or its designee.
- Provided not only as a convenience or comfort measure or to improve physical appearance.
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service.

The Plan reserves the right to determine whether a health care service meets these criteria. Approval for coverage based upon Medical Necessity shall be made by UPMC Health Plan, at its discretion, with input from the treating provider. Note that the fact that a provider orders, prescribes, recommends, or approves a health care service does not mean that the service is Medically Necessary or a Covered Benefit for purposes of coverage.

Member – An individual who is enrolled in and covered by the Certificate. References throughout this Certificate of Insurance to "you/your" refer to the Member.

Nonparticipating Dentist – A dentist who is not a contracted provider with the Plan.

Out-of-Pocket Maximum – The maximum dollar amount you are responsible for during a Benefit Period before the Plan will pay for all of your Covered Benefits. Deductible and copayments do count toward your Out- of-Pocket Maximum. See your Medical Schedule of Benefits for Out-of-Pocket Maximum amounts.

Participating Dentist – A dentist who has entered into an agreement with the Plan to render Covered Services to UPMC Health Plan Members.

Pediatric Dental Schedule of Benefits – List of Covered Services, Coinsurances, and limits.

Predetermination – The review of a treatment plan to determine the eligibility of a Member and the coverage for services in accordance with the Pediatric Dental Schedule of Benefits, the Schedule of Exclusions, and the Plan allowance for such services.

Prior Authorization — The process in which UPMC Health Plan reviews all reasonably necessary supporting information prior to the delivery or provision of a requested service and makes a decision to approve or deny payment for the service based on whether the service is Dentally/Medically Necessary. For certain treatment or services, you must obtain Prior Authorization prior to receiving the service by having your provider submit a Prior Authorization request that meets UPMC Health Plan's administrative requirements for such a request and includes the specific clinical information

necessary to evaluate the request.

Proof of Loss – Documentation to support a claim.

Salzmann Index – An assessment record used to disclose whether a handicapping malocclusion is present and to assess its severity according to the criteria and weights (point values) assigned to them for Member's entering orthodontic treatment.

Service Area – The Plan's primary Service Area, which consists of the counties listed in the most current version of the UPMC Health Plan provider directory. These are the counties in which UPMC Health Plan is licensed to do business and in which most of its Participating Dentists are located.

Treatment Plan(s) – The written report of a series of procedures recommended for the treatment of a specific dental disease, defect, or injury, prepared for a Member by a dentist as a result of an examination.

Usual, Customary, and Reasonable (UCR) – For the services authorized by UPMC Health Plan that are provided by a Participating or Nonparticipating Dentist, the UCR charge is the amount that UPMC Health Plan determines is reasonable for Covered Services pursuant to industry standards. Participating providers agreed to accept the UCR amount as payment in full. The Nonparticipating Dentist may charge you the difference between the billed amount and the UCR amount.

How the Dental Plan Works

Choosing a dental provider

You are enrolled in the UPMC Health Plan Preferred Provider Organization (PPO) dental plan. That means you have the ability to self-direct your care. You have two levels of benefits. You can use Participating Dentists, also called in-network providers, for all Covered Services as well as Nonparticipating Dentists, which are also called out-of-network providers, for most Covered Services. If you obtain services from Participating Dentists, you will receive the highest level of benefit coverage. If you obtain services from Nonparticipating Dentists, you will receive a lower level of benefit coverage. Be sure to read this Certificate of Insurance to determine whether a service will be covered if obtained from a Nonparticipating Dentist.

Remember, if you use Nonparticipating Dentists, you may receive a lower level of benefit coverage, and you may be billed by those Nonparticipating Dentists for the difference between the provider's charges and the allowed amount. This means that, because the Plan does not contract with a Nonparticipating Dentist, the provider can bill you for any amount over and above what the Plan covers. If you receive treatment from a Non-participating Dentist, we will send payment for Covered Benefits to you unless otherwise indicated on the claim form.

To find a Participating Dentist, visit us at www.upmchealthplan.com or call our Health Care Concierge team at **1-877-648-9640 (TTY: 711).** When you visit the dental office, let your dentist know that you are covered under UPMC Health Plan. If your dentist has questions about your eligibility or benefits, instruct the office to call **1-877-648-9609 (TTY: 711)** or visit www.upmchealthplan.com/dental.

Relationship with providers

UPMC Health Plan recognizes the importance of maintaining the continuity of care rendered to you by your treating dentists. Accordingly, to facilitate the management and quality of your overall treatment, the Plan may exchange information, including claims information, with your dentists.

The relationship between the Plan and Participating Dentists is that of independent contractors, and neither the Plan nor any Participating Dentist shall be considered an agent or representative of the other for any purpose.

The Plan makes no express or implied warranties or representations concerning the qualifications or continued participation of any Participating Dentist. The choice to use a particular provider is solely your own.

Participating Dentists may be terminated at the Plan's sole discretion. You may be required to choose another Participating Dentist if the provider rendering services to you terminates or is terminated from participation during the term of your enrollment, unless otherwise set forth herein or as required by state or federal law or regulation. You will be notified via letter if the provider rendering services to you is terminated.

The Plan does not provide or render Covered Services, but only makes payment or provides coverage for Dentally Necessary Covered Services that you receive. Participating Dentists are solely responsible for any dental services rendered to you and their other patients. The Plan is not liable for any act or omission of any provider who renders dental services to you. The Plan has no responsibility for a provider's failure or refusal to render health care services to you.

Residents outside Pennsylvania

UPMC Health Plan's Dental Provider Network is currently limited to the Commonwealth of Pennsylvania. UPMC Health Plans has partnered with DenteMax LLC to offer in-network benefits for Members with permanent residence outside Pennsylvania. To find a participating DenteMax dentist outside Pennsylvania, visit us at www.upmchealthplan.com or contact our Health Care Concierge team for assistance at 1-877-648- 9640 (TTY: 711).

When seeking dental care inside Pennsylvania, to receive in-network benefits, Members must always use a UPMC Health Plan Participating Dentist. Members residing in specific Pennsylvania counties outside of the primary Service Area may have access to Participating Dentists through the DenteMax network. For further information or a listing of eligible counties, visit www.upmchealthplan.com or call **1-877-648-9640 (TTY: 711).** If a Member sees a DenteMax dentist

located in any county located in Pennsylvania that is out-of-network and not a UPMC Health Plan Participating Dentist, then these benefits will be paid at the out-of-network rate.

Care when you are away from home
UPMC Health Plan recognizes that when you are traveling away from home, you may suffer a dental-related illness or injury. To receive all of the benefits of an in-network dentist while you are outside of the UPMC Health Plan Service Area, Members must access the DenteMax provider network. To find a participating DenteMax dentist outside of Pennsylvania, log into *My*Health OnLine via www.upmchealthplan.com and click on Find Care, then select Dental, which will bring you to the provider search page, or contact Member Services for assistance at **1-877-648-9640 (TTY: 711).**

Remember, out-of-network providers do not have to comply with UPMC Health Plan policies and procedures. If you receive out-of-network services, you may be financially responsible for the difference between what UPMC Health Plan reimburses the Nonparticipating Dentist and the amount billed for the treatment and services.

Predetermination
A Predetermination is a review by the Plan before treatment to determine Member eligibility and coverage for planned services. Predetermination is not required before you receive a service. However, it is recommended for extensive, more costly treatment, such as crowns and bridges. A Predetermination gives you and your dentist an estimate of your coverage and how much your Member cost sharing will be for the treatment being considered.

To have a service Predetermined, have your dental provider visit www.upmchealthplan.com to submit the Predetermination online or submit a claim showing the planned procedures but leaving out the dates of service. The treatment plan will determine benefits payable, taking into account exclusions. You will be notified of the estimated payment.

When the services are performed, have your dentist call 1-877-648-9609 TTY: 711) or submit an actual claim via Electronic Data Interchange (EDI), paper, or online through the UPMC Health Plan website (secure provider website). Any Predetermination amount estimated is subject to continued eligibility of the Member. We may also make adjustments at the time of final payment to correct any mathematical errors, apply coordination of benefits, and comply with your Plan in effect and the remaining program limit dollars available on the date of service.

This Predetermination in no way guarantees or implies that payment will be made. Payment is contingent upon the Member's benefit eligibility on the date services are rendered. The amount paid may be less than shown if benefits are payable under another plan that is primary.

Prior Authorization for orthodontic services
Orthodontic treatment is only covered by the Plan when deemed Medically Necessary. Providers must receive Prior Authorization before beginning treatment by completing and submitting a Salzmann Index Evaluation. Members must meet a score of 25 or greater to be considered eligible for orthodontic treatment. Scores of less than 25 are considered ineligible for treatment.

Members have the right to appeal denials for orthodontic treatment. Providers may also submit an appeal on behalf of a Member who has been denied coverage. Refer to the **Resolving Disputes with the Plan** section for additional information.

Orthodontic treatment performed by a Nonparticipating Dentist is not covered by the Plan.

Benefits

UPMC Health Plan provides coverage for the following dental services when those services are Dentally Necessary. Refer to your Pediatric Dental Schedule of Benefits for Deductibles and Coinsurance amounts as well as any Benefit Limits related to Covered Services. You may obtain Covered Services from either Participating or Nonparticipating Dentists and receive varying levels of coverage, as discussed throughout this Certificate.

Remember that a statement from your dentist saying he or she believes you should have certain services does not mean that those services are Covered Services for purposes of coverage under your benefit plan.

Any Affordable Care Act (ACA) requirements involving medical benefits will be included in your medical Policy.

Services
The general descriptions below explain the services on your Pediatric Dental Schedule of Benefits. The descriptions are *not* all-inclusive — they include only the most common dental procedures in a class or service grouping. Specific dental procedures may not be covered depending on your Plan. All services are subject to UPMC Health Plan policies and procedures. Refer to your Pediatric Dental Schedule of Benefits for Deductible and Coinsurance amounts as well as any Benefit Limits related to Covered Services. Services covered in your Pediatric Dental Schedule of Benefits are also subject to the Schedule of Exclusions included in this document and in your medical Policy. You may also log in to *My*Health OnLine at www.upmchealthplan.com to check coverage. Also, your dentist may call UPMC Health Plan to verify coverage of specific dental procedures.

Your dental services and procedures are divided into four classifications:

- Class I: Diagnostic/Preventive Services
- Class II: Basic Services
- Class III: Major Services
- Orthodontics (if medically necessary and performed by a Participating Dentist)

Each class has a specified percentage that will be paid by UPMC Health Plan for each service that you receive. Members should refer to their Pediatric Dental Schedule of Benefits for more information. Below you will find a list of services that fall into each class. This list of services is *not* all-inclusive — it includes only the most common dental services and procedures in a class or service grouping.

Class I: Diagnostic/Preventive Services

- Exams and x-rays for diagnosis, including:
  - Oral evaluations
  - Bitewing X-rays
  - Complete series and panoramic films
- Cleanings, fluoride treatments, and sealants for prevention
- Palliative treatment for relief of pain for dental emergencies
- Space maintainers to prevent tooth movement
- Nonsurgical periodontics for nonsurgical treatment of the gums and bones supporting the teeth, including:
  - Periodontal scaling and root planing
  - Periodontal maintenance

Class II: Basic Services

- Amalgam and composite fillings

- Extractions – nonsurgical removal of teeth and roots
- Pulpal therapy
- Endodontic therapy to treat the dental pulp, pulp chamber, and root canal – root canal treatment and retreatment, pulpotomy, pulpal therapy, apicoectomy, and apexification. Also includes:
    - Treatment plan
    - Clinical procedures
    - Follow-up care
- Surgical periodontics for surgical treatment of the tissues supporting and surrounding the teeth (gums and bone), including:
    - Gingivectomy
    - Gingivoplasty
    - Gingival flap procedure
    - Crown lengthening
    - Pin retention

Class III: Major Services

- Inlays, onlays, implants, and crowns when the teeth cannot be restored by fillings
- Prosthodontics
- Dentures (complete and partial)
- Replacement of missing or broken teeth

Orthodontics (if medically necessary and approved by UPMC Health Plan)
Orthodontics are subject to approval by UPMC Health Plan. Patients must meet a score of 25 or higher on the Salzmann scale to be eligible for treatment.

- For treatment of poor alignment and occlusion
- Coverage is for eligible children under the age 19 and includes:
    - Diagnostic x-rays
    - Active treatment
    - Pin Retention
- Orthodontics is also subject to the medical plan deductible
- Orthodontic treatment performed by a Nonparticipating Dentist is not covered by the Plan

Orthodontics is a lifetime benefit available to you during the duration of your coverage with your plan. If you or an eligible family member is undergoing orthodontic treatment on the effective date of your UPMC Health Plan coverage, your benefits will be transitioned in the following way, if deemed Medically Necessary and approved by UPMC Health Plan: UPMC Health Plan distributes the lifetime orthodontic benefit throughout the course of treatment for eligible Members. The payment schedule is determined based on the banding date and the estimated length of treatment (benefits may be prorated). If orthodontic treatment is already in progress on the effective date of your UPMC Health Plan coverage, your current orthodontist will receive the remainder of your maximum lifetime benefit from UPMC Health Plan based on the remaining months of treatment and the dental EHB plan design.

Eligible EHB Members must satisfy their shared medical/orthodontic dental Deductible before the Plan makes any payments.

Anesthesia
Anesthesia is not payable under UPMC Health Plan's dental plan. However, the Member may have coverage for anesthesia services under his or her medical benefits.

General anesthesia and associated medical costs are provided to an eligible dental patient, which includes children 7 years of age or younger or developmentally disabled Members of any age for whom a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected for treatment under general anesthesia.

Anesthesia coverage under the Member's medical plan may have limitations, restrictions, and requirements. Please refer to your medical Policy or plan documents.

Pediatric Dental Schedule of Benefits
Your benefits are shown in the enclosed Pediatric Dental Schedule of Benefits. The Pediatric Dental Schedule of Benefits shows:

- The classes of dental services covered, shown with the percentage of the Usual, Customary, and Reasonable charges that the Plan pays for those services as well as examples of services covered in each class.
- Any Member out-of-pocket costs or cost sharing for a Covered Service.
- Any Deductibles you and/or your family must pay per Benefit Period before any covered services will be paid by the Plan and the Covered Services for which there are no Deductibles.
- Any limits for Covered Services for a given period of time, for example, annual for most services and lifetime for orthodontics. Annual limits are applied on a Benefit Period basis.

Your out-of-pocket costs
In order to keep the plan affordable for you, the dental plan includes certain cost-sharing features. If the class or service grouping is not covered under the plan, the Pediatric Dental Schedule of Benefits will indicate "not covered." You will be responsible to pay your dentist the full charges for services that are not Covered Services.

Classes or service groupings shown with "Plan Pays" percentages greater than 0 percent but less than 100 percent require you to pay a portion of the cost for the Covered Service. For example, if the dental plan pays 80 percent, your share, or Coinsurance, is 20 percent of the Usual, Customary, and Reasonable charges. You are also responsible for paying any Deductibles and charges exceeding the limits. The individual Deductible applies when a Certificate covers one Member up to 19 years old. For policies with two or more Members up to 19 years old, the eligible dependents Deductible applies. Copayments, Coinsurance, and Deductible for dental benefits apply toward satisfaction of the Out-of-Pocket Maximum specified in your Medical Schedule of Benefits.

Exclusions
No benefits will be provided for services, supplies, or charges detailed in the Schedule of Exclusions.

Claims

Claims submissions

If you receive care from a Participating Dentist, you should not have to submit a claim to the Plan. The Participating Dentist will bill the Plan, and the Plan will pay the provider directly. However, if you obtain Dentally Necessary Covered Services from a Nonparticipating Dentist, you may have to file a claim yourself. To submit a claim, follow the steps below.

To obtain a claim form, log in to *My*Health OnLine via www.upmchealthplan.com or contact Member Services at (1-877-648-9640 (TTY:711). Be sure to include the following on the claim form:

- Member's Name
- Member's ID Number
- Member's Address
- Member's Signature
- Member or Provider Pay Selection
- Date of Service
- Services Rendered, along with quadrant and tooth numbers if applicable
- Billed amounts
- Member Proof of Payment
- EOP from Primary Insurance if applicable

For approved orthodontic treatment, covered under the plan, an explanation of the planned treatment (treatment plan) must be submitted to the Plan. Upon review of the information, we will notify you and your dentist of the reimbursement schedule, frequency of payment over the course of treatment, and your share of the cost. Claim forms should be sent to:

UPMC Dental Advantage
P.O. Box 1600
Pittsburgh, PA 15230-1600

Remember, a request for payment of a claim will not be reviewed, and no payment will be made unless all of the information described above has been submitted to the Plan. The Plan reserves the right to require additional information and documents, if necessary, to support your claim. Should you have any questions concerning your coverage, eligibility, or a specific claim, contact UPMC Health Plan at **1-877-648- 9640 TTY: 711)** or log in to *My*Health OnLine at www.upmchealthplan.com.

Notice of claim

The Plan will not be liable under this Certificate unless proper notice is furnished to the Plan that Covered Services in this Certificate have been rendered to a Member. Written notice must be given to the Plan within 20 daysof the date in which the Covered Services were rendered or as soon as reasonably possible thereafter. You must give notice to the Plan in writing at UPMC Health Plan, P.O. Box 1600, Pittsburgh, PA 15230-1600. The notice must include the data necessary for the Plan to determine benefits. A charge shall be considered "incurred" on the date the Member receives the service or supply for which the charge is made.

Claim forms

Proof of Loss for benefits under this Certificate must be submitted to the Plan on the appropriate claim form. The Plan, upon receipt of notice of claim will, within 15 days of the date the notice of a claim is received, furnish claim forms to you for filing Proofs of Loss. If claim forms are not furnished within 15 days after the giving of such notice, you shall be deemed to have complied with the requirements of this subsection as to filing a Proof of Loss upon submitting, within 90 days, itemized bills for Covered Services as described below. The Proof of Loss may be submitted to the Plan at the claim address provided above.

Proof of Loss
Written Proof of Loss must be furnished to the Plan within 90 days after the date of such loss. Failure to give notice to the Plan within the time required will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no case, except in the absence of legal capacity, will the Plan be required to accept notice later than one year after the end date in which the Covered Service was rendered.

Timely payment of claims
Subject to written Proof of Loss, all claims payable under this Certificate will be paid immediately, according to any applicable regulatory requirements. For submitted claims, the Plan will not be liable under this Certificate unless proper notice is furnished to the Plan that Covered Services have been rendered to you.

UPMC Health Plan will not be responsible for payment of claims for Covered Services that are submitted more than one year from the date of service.

Payment of claims
Claims payable under this Certificate when loss of life has occurred will be payable in accordance with the beneficiary designation and the provisions respecting such payment, which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, claims shall be payable to the estate of the insured. Any other accrued claims unpaid at the insured's death may, at the option of the Plan, be paid either to such beneficiary or to such estate. All other claims will be payable to the insured.

Payment of benefits
If you have treatment performed by a Participating Dentist, we will pay Covered Benefits directly to the Participating Dentist. Both you and the dentist will be notified of Plan payment and any amounts you owe for Coinsurance, Deductibles, charges exceeding limits, or denial of noncovered services. Payment will be based on the Usual, Customary, and Reasonable charges that the treating Participating Dentist has contracted to accept and what your benefit allows.

If you receive treatment from a Non-participating Dentist, you will be notified of the Plan payment and any amounts you owe for Coinsurance, Deductibles, charges exceeding limits, or denial of noncovered services. The Plan payment will be based on the Usual, Customary, and Reasonable charge for the services. You will be responsible to pay the dentist any difference between the Plan's payment and the dentist's full charge for the service.

Change of Beneficiary
The right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Certificate or to any change of beneficiary or beneficiaries, or to any other changes in this Certificate.

Overpayments
If we make an overpayment for benefits, we have the right to recover the overpayment. In the event that overpayment was made to the Member, we will recover the overpayment by requesting a refund. Recovery will be done in accordance with any applicable state laws or regulations.

Coordination of benefits
When a Member is eligible for coverage under more than one dental plan, the Plan will coordinate your benefits with those plans. The Plan does this to make sure that your benefits will be paid appropriately while preventing duplicate payments. This is how coordination of benefits works for your benefit plan:

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by that coverage will be taken into account when we determine if additional benefit payments can be made under this plan.
- When you are covered as an employee under one plan and as a dependent under another, the employee coverage pays first.
- When the dependent child is covered under two plans, the plan covering the parent whose birthday occurs earlier in the calendar year pays first. If both parents have the same birthday, then the plan under which one parent was

covered longest pays first.

- If the dependent child's parents are separated or divorced and:
    - The parent with custody of the child has not remarried, the coverage of the parent with custody pays first.
    - The parent with custody has remarried, the coverage of the parent with custody pays first, but the stepparent's coverage, if any, pays before the coverage of the parent without custody.
    - There is a court order that specifies the parent who is financially responsible for the child's dental expenses, the coverage of that parent pays first.
- When none of the above circumstances applies, the coverage that you have had the longest applies first, as long as:
    - The benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person, and the other plan does not have a provision regarding laid-off or retired employees and, therefore, the benefits of each plan are determined after the other, then the provisions listed above shall not apply.

If you or your provider receive more than you should have when your benefits are coordinated, you or your provider will be expected to repay the overpayment. It is the policy of UPMC Health Plan to review all other insurance coverage prior to releasing a claim for payment. If other insurance coverage is found after a payment has been made, a review will determine which plan pays first and what action will be taken ~~i~~n regard to any claims in question. Whenever payments should have been made by the Plan, but payments were made under another benefit plan, UPMC Health Plan has the right to pay to the benefit plan that has made such payment any amount that the Plan determines to be appropriate under the terms of this Certificate. Any amounts paid shall be considered to be benefits paid in full under this Certificate.

If the Plan makes payment for Covered Services in excess of the amount of payment pursuant to this Certificate, irrespective of to whom those amounts were paid, UPMC Health Plan shall have the right to recover the excess amount from any person or entity to or for whom such payments were made. Upon reasonable request by the Plan or its agent, you must execute and deliver such documents as may be required and do whatever else is reasonably necessary to secure the UPMC Health Plan's rights to recover the excess payments.

UPMC Health Plan is not required to determine whether or not you have other dental benefits or insurance or the amount of benefits payable under any other dental benefits or insurance. The Plan shall only be responsible for coordination of benefits to the extent that information regarding your other insurance is provided to the Plan by you, the school or university which provided this Certificate, another insurance company, or any other entity or person authorized to provide such information.

Review of a benefit determination

If you are not satisfied with the Plan's benefit determination, please contact us at **1-877-648-9640 (TTY:711).** If you are still dissatisfied after speaking with a Health Care Concierge, refer to the **Resolving Disputes with the Plan** subsection of this Certificate for further steps you can take regarding your claim.

Resolving Disputes with the Plan

At times, you may not be satisfied with a decision that UPMC Health Plan makes regarding your coverage or with the health care services you have received. A dispute about the coverage, operations, or management policies of UPMC Health Plan is called a "Complaint." A dispute regarding UPMC Health Plan's denial, reduction, or termination of a benefit, or failure to make payment for a benefit – also known as an "Adverse Benefit Determination" – is called an "Appeal."

The Complaint process

If you have a dispute or objection regarding the coverage, operations, or management policies of UPMC Health Plan, or about a UPMC Health Plan Participating Provider, you may submit a Complaint to UPMC Health Plan. Complaints may be submitted about issues including, but not limited to, quality of care or services, benefits exclusions, or coordination of benefits. The Complaint process offers two levels of review.

At any time during the Complaint process, you may choose to designate a representative to act on your behalf. You must notify UPMC Health Plan in writing that you are designating someone to represent you and include a signed Personal Representative Designation (PRD) form signed by you and your designee. To obtain a PRD Form, visit www.upmchealthplan.com or call the Member Services number on your member identification card.

You or your representative may file a Complaint with the UPMC Health Plan in writing or over the phone. You can also file a Complaint online by completing the online "Complaint or Appeal Submission Form" which can be found on MyHealth Online. To submit a Complaint in writing, please mail your complaint to PO Box 2939, Pittsburgh, PA 15230-2939. You are encouraged to send any other written information you have to support your Complaint. Include in the Complaint the remedy, resolution, or corrective action you want from UPMC Health Plan.

To submit a Complaint over the phone, you or your representative may call the Member Services phone number on your member identification card. A Health Plan employee will assist you or your representative, at no charge, to prepare your Complaint, but will not be able to resolve your Complaint. This employee will not have previously participated in any of UPMC Health Plan's decisions regarding your Complaint.

First Level Complaint

You must submit your First Level Complaint within 180 days of the date on which the incident occurred. UPMC Health Plan will send you a letter to let you know we received the Complaint.

A First Level Complaint Review Committee will investigate the allegations in your Complaint within 30 days of receipt of your Complaint.-The Committee will notify you of its decision in writing within five (5) business days of receipt of your Complaint decision. The notification letter will explain the Committee's decision and describe the process by which you may request a second level review of the decision.

Second Level Complaint

If you are not satisfied with the results of your First Level Complaint, you can request another review. You have 60 days from the date of a First Level Complaint Review Committee's decision letter to request another review. If you choose not to request a second level review within that time frame, the decision of the First Level Complaint Review Committee will be final.

If you submit a Second Level Complaint, UPMC Health Plan will send you a letter to let you know that we received your Complaint. We will also tell you the date and time for your Second Level Complaint Review Committee meeting. UPMC Health Plan will give you at least 15 days' notice of the meeting. We will also explain what happens at review meetings and how you can participate in the meeting. You and/or your representative have the right, but are not required, to attend the Second Level Complaint Review Committee meeting. The meeting will be held at the offices of UPMC Health Plan.

If you or your representative cannot appear in person at the Second Level Complaint Review Committee meeting, UPMC Health Plan will provide you with the opportunity to participate in the review by telephone or other appropriate and available means. We will be as flexible as is reasonably possible in facilitating your participation.

The Second Level Complaint review will be completed within 45 days of receiving your request for such review. The Second Level Complaint Review Committee will issue a decision in writing to you and your representative no more than five business days after the date of the meeting.

You are entitled to receive, upon request, reasonable access to and copies of all documents relevant to your Complaint. To request this documentation, please call the phone number on your member identification card.

The Adverse Benefit Determination Appeal process
You have the right to appeal any Adverse Benefit Determination made by UPMC Health Plan. An Adverse Benefit Determination includes the following:

1. A decision that a service is not covered because it is not Medically Necessary (including decisions about the appropriateness of service, health care setting, level of care, or effectiveness of a service);

2. A decision that a service is Experimental/Investigational;

3. An "Administrative Denial." An administrative denial is a decision to deny authorization, coverage, or payment for a service because: (a) you are not eligible for coverage; (b) you or your provider failed to submit sufficient information with which to make a coverage decision; or (c) or your provider has failed to comply with an administrative policy of UPMC Health Plan.

4. A rescission of your coverage (cancellation of coverage based on a claim that you gave false or incomplete information when you applied for coverage).

You, your designated representative, or your provider who has your written consent may file an Appeal of an Adverse Benefit Determination. We will refer to a provider who has your written consent to file an Appeal as your provider. If you have given written consent to file an Appeal, please read the section below for more information.

You or your representative may file an Appeal with UPMC Health Plan in writing or over the phone. You can also file an Appeal online by completing the online "Complaint or Appeal Submission Form" which can be found on MyHealth Online. To submit an Appeal in writing, please mail your written Appeal to P.O. Box 2939, Pittsburgh, PA 15230-2939. You are encouraged to send any other written information to support your Appeal. You may include in the Appeal the remedy, resolution, or corrective action you want from UPMC Health Plan.

To submit an Appeal over the phone, you or your representative may call the Member Services phone number on your member identification card. A Health Plan employee will assist you or your representative, at no charge, to prepare your Appeal, but will not be able to resolve your Appeal. This employee will not have previously participated in any of UPMC Health Plan's decisions regarding your Appeal.

Provider-Initiated Appeals
You may give your provider consent to file an Appeal on your behalf. Please note that if you do so, you cannot file your own Appeal for the same denied treatment or service.

Here are some important rights regarding giving your provider consent to file an Appeal on your behalf:

- If you give your provider consent to file an Appeal on your behalf, that consent must be in writing, it must contain certainly language required by law, and it can be rescinded at any time.
- Your provider may not require you to give the provider permission to file an Appeal on your behalf as a condition of providing a treatment or service.
- Your provider must notify you if the provider decides not to file the Appeal.

- Your provider has 10 days to file an Appeal from the date of the denial of the treatment or services, and their ability to file an Appeal on your behalf is automatically rescinded if they fail to do so.
- If your provider files the Appeal on your behalf, your provider may not bill you for services that are the subject of the Appeal until the External Review process has been completed or you rescind your consent.

Internal Appeals

UPMC Health Plan's Adverse Benefit Determination appeal process offers one level of review. You must submit your Appeal within 180 days of the date on which the denial occurred. For example, if your Appeal is regarding denial of prior authorization for a service, you must file the Appeal within 180 days of the date on the letter you received informing you of that denial. While it is preferable that you file an Appeal in writing, you may call UPMC Health Plan to request assistance and file an Appeal verbally. UPMC Health Plan will send you a letter to let you know your Appeal was received. UPMC Health Plan may also contact you to ask for additional information, if necessary to process your Appeal.

An Adverse Benefit Determination Review Committee will investigate the allegations set forth in the Appeal. The Committee will seek input from a licensed health care provider with experience in the same or similar specialty that typically manages or consults regarding the disputed health care service. If the Committee relies on or considers new or additional information in reviewing your Appeal or develops a new or additional rationale in denying your claim, it will provide that information to you free of charge. The Committee will also give you a reasonable opportunity to respond before issuing a decision.

The Committee will notify you and your representative of its decision within 30 days of receipt of your Appeal. The notification letter will explain the Committee's decision and any additional appeal rights. A copy of the decision letter will be sent to you and/or your representation and/or your provider, as applicable.

You are entitled to receive, upon request, reasonable access to either copies of all documents relevant to your Appeal or instructions on how to obtain the documents. Documentation may include the benefit provision, guideline, protocol, diagnosis codes, or treatment codes on which the decision was based. To request this documentation, please call the phone number on your member identification card.

The External Review process
If you and/or your provider are still dissatisfied with UPMC Health Plan's final decision regarding your Complaint or Adverse Benefit Determination, you may have the right to file a request for an external review by an Independent Review Organization (IRO).

An External Review may be requested for the following issues:

1. A decision that a service is not covered because it is not Medically Necessary (including decisions about the appropriateness of service, health care setting, level of care, or effectiveness of a service);

2. A decision that a service is Experimental/Investigational;

3. Disputes regarding UPMC Health Plan's compliance with the surprise-billing and cost-sharing protections of the No Surprises Act.

Note that Administrative Denials are not eligible for external review by an IRO.

You, your representative, or your provider may file a request for an external review with the Pennsylvania Insurance Department within four (4) months of the date on the Committee's decision letter. For more information on the independent external review process, you can visit the Pennsylvania Insurance Department's website at: www.insurance.pa.gov/externalreview.

To submit a request for either standard or expedited independent external review (expedited reviews are discussed in more detail below), you must submit a copy of your Adverse Benefit Determination or Final Adverse Benefit Determination notice and a completed independent external review request form to:

Mail: Pennsylvania Insurance Department
Attn: Bureau of Managed Care
1311 Strawberry Square
Harrisburg, PA 17120

Fax: 717-231-7960
Email: RA-IN-ExternalReview@pa.gov
Phone: Consumer Services, 1-877-881-6388

For an external review of a determination that a service is Experimental/Investigational, your provider must certify that standard healthcare services have not been effective in improving your condition, standard Covered Services are not medically appropriate, or that the requested service is likely to be more beneficial than any standard Covered Services, based on the provider's professional opinion or based on scientifically valid studies.

Once PID receives your request, the Insurance Department will confirm your eligibility for independent external review with UPMC Health Plan. UPMC Health Plan will complete a preliminary review within five (5) business days to determine whether: (1) you are a covered Member; (2) the service requested is a Covered Service under your plan (or would be a Covered Service if not Experimental/Investigational); (3) you exhausted internal appeals; and (4) you provided all information and forms necessary to process the external review.

Within one (1) business day after completion of the preliminary review, UPMC Health Plan will issue a notification to you and PID in writing as to whether or not your Adverse Benefit Determination is eligible for an external review. We will tell you if we need additional information to determine eligibility for an external review. If we need additional information, we will tell you what we need and allow you to submit the additional information within the four-month filing period or within the 48-hour period following your receipt of notification, whichever is later.

If your Adverse Benefit determination or Final Adverse Benefit Determination is eligible for independent external review, the Pennsylvania Insurance Department will assign an Independent Review Organization (IRO) and provide you with notice of the assignment and information on how you may submit information to support your position.

Within five (5) business days of determining that your appeal is eligible for external review, UPMC Health Plan will forward a copy of all written documentation regarding the Adverse Benefit Determination to the IRO. Documentation will include the correspondence concerning the decision, all reasonable supporting documentation, and a summary of the clinical rationale for the adverse determination. At the same time, UPMC Health Plan will provide you, your representative, or your provider with the list of documents that are being forwarded to the IRO for the external review.

You, your representative, or your provider may supply additional information to the IRO to consider in the external review within 15 business days of notification that your Adverse Benefit Determination is eligible for external review (5 business days in the case of an external review of an Experimental/Investigational decision). The IRO will forward any additional information it receives to UPMC Health Plan to supplement our records.

The IRO will review all information UPMC Health Plan and you, your representative, or your provider provided. The Independent Review Organization will issue a decision to uphold, partially uphold, or overturn UPMC Health Plan's decision based on the information provided by you and UPMC Health Plan. The IRO will issue a decision within 45 days of receipt of the external review (20 days in the case of a review of an Experimental/Investigational decision). The decision will be issued in writing to UPMC Health Plan, you, your representative, or your physician. The decision notification will include the basis and clinical rationale for the decision, the credentials of the individual reviewer, and a list of information considered in the decision.

You are entitled to receive, upon request, reasonable access to and copies of all documents relevant to your Complaint or Appeal. Documentation includes the benefit provision, guideline, diagnosis codes, or treatment codes on which the decision was based. If you have any questions, please call the number on your member identification card.

Expedited review process
If you believe your life, health, or ability to regain maximum function may be jeopardized due to the standard time frames for standard internal Complaint or Adverse Benefit Determination review, you may request an expedited internal review from UPMC Health Plan and/or an expedited external review request from the Pennsylvania Insurance Department at any stage of the Plan's review process.

Expedited internal review process
You may request an expedited internal review if your life, health, or ability to regain maximum function may be jeopardized due to the standard time frames for a standard internal review.

To request an expedited review, you should contact Member Services and explain the need for an expedited review. You must obtain written certification from your treating provider that your life, health, or ability to regain maximum function would be placed in jeopardy by the delay inherent in the regular time frames of the internal Complaint or Adverse Benefit Determination process. The certification must include a clinical rationale and facts to support your provider's position. In the case of a review of a decision that a treatment is Experimental/Investigational, your treating provider must certify that the services that are the subject of the request would be significantly less effective if not promptly initiated. UPMC Health Plan will inform you of the decision verbally and in writing.

The expedited review process follows all the requirements of a standard second level review, with the following exceptions:

- If UPMC Health Plan cannot accommodate you or the committee members as to time and distance to be present at the review, the review may be held by telephone or other appropriate and available means. UPMC Health Plan will ensure that all appropriate information is read into the record.
- You must provide any additional information for consideration in an expedited manner so UPMC Health Plan can comply with the requirements for an expedited review.
- The internal committee will issue a decision within 72 hours of receipt of the request for review and the provider certification described above.

Expedited external review process
You may request an expedited external review if your life, health, or ability to regain maximum function may be jeopardized due to the standard time frames for a standard internal review. You may also request an expedited external review following exhaustion of the internal Adverse Benefit Determination review process if the Adverse Benefit Determination at issue concerns an admission, availability of care, continued stay, or health care service for which you received emergency services but have not been discharged from the facility.

To request an expedited external review, you should contact the Pennsylvania Insurance Department. For more information on the independent external review process, you can visit the Pennsylvania Insurance Department's website at: www.insurance.pa.gov/externalreview.

To submit a request for either standard or expedited independent external review, you must submit a copy of your Adverse Benefit Determination or Final Adverse Benefit Determination notice and a completed independent external review request form to:

Mail: Pennsylvania Insurance Department
Attn: Bureau of Managed Care
1311 Strawberry Square
Harrisburg, PA 17120

Fax: 717-231-7960
Email: RA-IN-ExternalReview@pa.gov

Phone: Consumer Services, 1-877-881-6388

The request must include written certification from your treating provider that your life, health, or ability to regain maximum function would be placed in jeopardy by the delay inherent in the regular time frames of the internal Complaint or Adverse Benefit Determination process. In the case of a review of a decision that a treatment is Experimental/Investigational, your treating provider must certify that the services that are the subject of the request would be significantly less effective if not promptly initiated.

Within 24 hours, the Department will send a copy of the request to UPMC Health Plan, which will determine your eligibility for an expedited external review within 24 hours. Following this decision, the Department will, within 24 hours, assign an IRO to review the issue. The IRO will provide you with notice of its decision as quickly as possible, but not later than 72 hours after our receipt of your request for the expedited external review.

Appeal of a Complaint or Administrative Adverse Benefit Determination decision to a governing agency

If you are dissatisfied with UPMC Health Plan's decision regarding your Complaint or Adverse Benefit Determination, you may have the right to file an appeal of our decision with the Pennsylvania Insurance Department. Your appeal must be filed within 15 calendar days after you receive the final decision letter regarding your Complaint or Adverse Benefit Determination Appeal.

You may also submit a complaint or appeal to the Pennsylvania Insurance Department in writing, to either of the following addresses:

Bureau of Managed Care of the Pennsylvania Insurance Department, 1311 Strawberry Square
Harrisburg, PA 17120 (1-888-466-2787)
Bureau of Consumer Services of the Pennsylvania Insurance Department, 1209 Strawberry Square,
Harrisburg, PA 17120 (1-877-881-6388)

Your request should be in writing, although the Pennsylvania Insurance Department will make staff available to transcribe a verbal appeal. You should provide the following information when filing a complaint or appeal:

- Your name, address, and telephone number
- Name of the managed care plan
- UPMC Member identification number
- A brief description of the issue being appealed
- A copy of the adverse decision letter that UPMC Health Plan sent to you

Schedule of Exclusions

What is not covered

Not all dental services are Covered Services. The following is a list of services that are not covered under your benefit plan. If you are not sure if a service is covered, call us at 1-877-648-9640 (TTY: 711) to ask if that service is covered under your dental plan.

- **Blood**: Nonpurchased blood or blood products, including autologous donations.
- **Cosmetic surgery**: Surgical or other services performed solely for cosmetic reasons — to repair or reshape a body structure for the improvement of the person's appearance or for psychological or emotional reasons and from which no improvement in physiological function can be expected, such as mouth guards and adult fluorides.
- **Court-ordered services**: Court-ordered services when your dentist or other professional provider determines that those services are not dentally appropriate.
- **Employment-related or employer-sponsored services**:
    A. For any illness or bodily injury that occurs in the course of employment, if benefits or compensation is available in whole or in part, pursuant to any federal, state, or local government's workers' compensation, or occupational disease, or similar type of legislation. This exclusion applies whether or not you claim those benefits or compensation.
    B. Services that you receive from a dental or medical department, operated in whole or in part by, or on behalf of, an employer, mutual benefit association, labor union, trust, or similar entity.
- **Experimental/Investigational**: Services that are Experimental/Investigational in nature as determined by the Plan.
- **Medical/Dental services not identified as "covered" in this Certificate**: Any other medical or dental service or treatment, except as provided in this Certificate or as mandated by law.
- **Medicare**: Services for which or to the extent that payment has been made pursuant to Medicare coverage, when Medicare coverage is primary.
- **Military service**:
    A. Care for military service-connected disabilities and conditions for which you are legally entitled to services and for which facilities are reasonably accessible to you.
    B. Services that are provided to Members of the armed forces and the National Health Service or to individuals in Veterans Affairs facilities for military service-related illness or injury, unless you have a legal obligation to pay.
- **Miscellaneous**: Any services, supplies, or treatments not specifically listed in the Certificate as covered benefits, services, supplies, or treatments, unless they are a basic dental service.
    A. Any services related to or necessitated by an excluded item or noncovered service.
    B. Services provided by a unlicensed practitioner.
    C. Services that are primarily educational in nature, including, but not limited to, instruction for plaque control, oral hygiene, and diet.
    D. Services incurred after the date of termination of your coverage, except as provided elsewhere in this Certificate.
    E. Services rendered prior to the effective date of your coverage.
    F. Services for which you otherwise would have no legal obligation to pay.
    G. Charges for telephone consultations unless otherwise allowed in accordance with Plan policy.
    H. Charges for failure to keep a scheduled appointment.
    I. Services performed by a dentist enrolled in an education or training program when such services are related to the education or training program.
    J. Charges for completion of any insurance form or copying of dental or medical records.
    K. Services that are submitted by two different dentists for the same services performed on the same date for the same individual.
    L. Services for, or related to, any illness or injury suffered after the effective date of your coverage that is the result of any act of war.
    M. Services that are more than the Usual, Customary, and Reasonable charge.
    N. Charges for care that is not Dentally Necessary.

O. Expenses incurred by you to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. The Plan will take into account any adjustment option chosen under such part by you.
P. Replacement of a lost or stolen appliance.
Q. Replacement of a bridge, crown, or denture within 60 months after the date it was originally installed.
R. Procedures, appliances, or restorations (except full dentures) whose main purpose is to (a) change vertical dimension, (b) diagnose or treat conditions or dysfunction of the temporomandibular joint, (c) stabilize periodontally involved teeth, or (d) restore occlusion to include orthodontics for Members age 19 and over.
S. Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second, or third molars.

- **Motor vehicle accident/workers' compensation**: Treatment or services for injuries resulting from the maintenance or use of a motor vehicle to the extent such treatment or service is paid or payable under a motor vehicle insurance policy, or any injury sustained in the course and scope of performing work for which coverage is afforded under a workers' compensation policy, including, but not limited to, a qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical or dental benefits established by law, including medical benefits payment in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act or equivalent law of another state.
- **Oral surgery**: Services, including or related to oral surgery, except as otherwise set forth herein. Exclusions include, but are not limited to, (a) services that are part of an orthodontic treatment program; (b) services required for correction of an occlusal defect; (c) services encompassing orthognathic or prognathic surgical procedures; (d) treatment of temporomandibular joint syndrome or temporomandibular joint disorders; (e) removal of asymptomatic, nonimpacted third molars; and (f) orthodontics and related services.
- **Prescription drugs**.
- **Temporomandibular joint syndrome**: In order for surgery to be covered, documentation in the medical record must support that treatment of TMJ disorder with conventional nonsurgical therapy has not resulted in adequate improvement, except as set forth in this Certificate.

General Provisions

This Certificate includes and incorporates any and all Schedule of Benefits the Pediatric Dental Certificate of Insurance and Pediatric Dental Schedule of Benefits represent the entire agreement between the parties with respect to the subject matter. The failure of any section or subsection of this Certificate shall not affect the validity, legality, and enforceability of the remaining sections.

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

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

Amendment
Anything contained herein to the contrary notwithstanding, UPMC Health Plan shall have the right, for the purpose of complying with the provisions of any law or any lawful order of a regulatory authority, to amend the Certificate or any attachment hereto or to increase, reduce, or eliminate any of the benefits provided for in the Certificate for any one or more eligible Members enrolled under the Certificate, and each party hereby agrees to any amendment of the Certificate which is necessary in order to accomplish such purpose.

Application and statements
Applicants for coverage under this plan shall complete and submit such application or other forms or statements as UPMC Health Plan may reasonably request. Applicants for coverage under this plan represent that all information contained in such application forms, or statements submitted for enrollment under this Certificate or the administration hereof shall be true, correct, and complete to the best of their knowledge or belief, and all rights to benefits hereunder are subject to the condition that such information shall be true, correct, and complete. A person who knowingly and with intent to defraud UPMC Health Plan by completing forms containing false information or by omitting relevant information commits a fraudulent insurance act, which is a crime and may be subject to criminal and civil penalties or the termination of coverage hereunder. Please see the Time limit on certain defenses (below) provision regarding information you submitted.

Entire contract; changes
Subject to the contract between your school or university and UPMC Health Plan, this Certificate of Insurance, including the schedules, riders and other documents attached hereto and issued in accordance herewith, represents the entire contract of insurance between your school or university and UPMC Health Plan. No change in this Certificate shall be valid until approved by a Health Plan officer and unless such approval be endorsed hereon or attached hereto.

Fraud, waste and abuse
According to Pennsylvania statute:

Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claim containing any materially false information**,** or conceals for the purpose of misleading**,** information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

UPMC Health Plan is committed to the integrity of, provision of, and payment for health care services to our Members. In the event that you suspect that a **UPMC Health Plan** Member or a provider is committing fraud**,** waste or abuse, call or email contact our Special Investigations Unit at **1-866-FRAUD01(1-888-372-8301**) or specialinvestigationsunit@upmc.edu**.**

Governing law
This Certificate is entered into and is subject to the laws of the Commonwealth of Pennsylvania. The invalidity or unenforceability of any terms or conditions hereof in no way affects the validity or enforceability of any other terms or provision. The waiver by either party of a breach or violation of any provision of this Certificate shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

Legal actions
No action in law or in equity will be brought to recover on this coverage prior to the expiration of sixty (60) days after written proof of loss for Covered Services has been furnished in accordance with the requirements of this Certificate. No such action will be brought after the expiration of three (3) years after the time written proof of claims for Covered Services was required to be furnished.

Misstatement of age
If your age has been misstated, all amounts payable under the plan shall be the premium amount owed if the plan had been purchased at the correct age. UPMC Health Plan shall notify you of the correct premium amount immediately following its discovery of the error. The correct premium amount shall also be applied retroactively, which may result in you owing additional premium amounts as of the Effective Date of your Certificate.

If UPMC Health Plan accepts payment of a premium for coverage extending beyond the date determined in the subsection titled Time limit on certain defenses (below), then coverage will continue, except if the acceptance of premium was based on a misstatement of age.

Physical examinations
The Plan, at its own expense, shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder.

Grace period
Subject to meeting the eligibility requirements as determined by your school or university which provided this Certificate, a grace period of thirty (30) days from the due date will be granted for payment of the required premium. During the grace period, the Certificate will remain in force. If the required premium payment is not received by the end of the thirty (30)-day grace period, the Certificate will automatically terminate effective the end of the Grace Period. Any claims received and found otherwise eligible during the Grace Period will be paid and may be reduced by any then outstanding premiums.

Reinstatement
If your coverage under this Certificate has been terminated for failure to pay premiums, the plan will reinstate your coverage as long as the premium due is paid in full within 30-calendar days after the end of the grace period and you meet the eligibility requirements as determined by your school or university which is provided in this Certificate. In all other respects the insured and insurer shall have the same rights thereunder as they had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

Release of information
Each Member agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under the Certificate may furnish to UPMC Health Plan, upon its request, any information (including copies of records) relating to the illness or injury. In addition, UPMC Health Plan may furnish similar information regarding claims and charges that providers submitted to UPMC Health Plan to other entities that provide similar benefits at the entity's request. Each Member further agrees that approval by UPMC Health Plan of any benefits for services rendered under the Certificate is contingent upon furnishing such information or records or copies of records.

Time Limit on Certain Defenses
No misstatements, except fraudulent misstatements, made by the applicant in the application for such coverage shall be used to void this plan or to deny a claim commencing after the expiration of three years from the date of issue of this Certificate. All statements you made will, in the absence of fraud, be deemed representation, and not warranties, and no such statement will be in defense to a claim under this Certificate, unless it is contained in a written instrument signed by and furnished to you. UPMC Health Plan will not reduce or deny any claim for loss that you may incur from the date your plan started on the grounds that a disease or physical condition existed before the date your plan started, unless the disease or physical condition was excluded from coverage by name or by a specific description that was in effect on the date of loss. Material misrepresentations will, at the option of UPMC Health Plan, render this plan void from inception, provided that such material misrepresentations are discovered by UPMC Health Plan within three (3) years of the Effective Date. In

the event UPMC Health Plan elects to void this Plan, you forfeit any charges paid to the extent of any liability incurred by UPMC Health Plan.

Nondiscrimination Notice

UPMC Health Plan[1], on behalf of itself and its affiliates, complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression or sexual orientation.

UPMC Health Plan:

- UPMC Health Plan provides free aids and services to people with disabilities so that they can communicate effectively with us. Aids and services may include:
    - Qualified sign language interpreters.
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- UPMC Health Plan provides free language services to people whose primary language is not English. Language services may include:
    - Qualified interpreters.
    - Information written in other languages.

If you need these services, contact the Member Services phone number listed on the back of your member ID card.

If you believe that UPMC Health Plan has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression, you can file a complaint with:

Complaints and Grievances PO
Box 2939
Pittsburgh, PA 15230-2939

Phone: 1-888-876-2756 (TTY: 711)
Fax: 1-412-454-7920
Email: HealthPlanCompliance@upmc.edu

You can 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, DC 20201, 1-800-368-1019. TTY/TDD users should call 1-800-537-7697.

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

[1]UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC for You Inc., Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

Translation Services
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-489-3494 (TTY:711).

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 1-855-489-3494
（TTY：711）

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-489-3494 (TTY:711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-489-3494 (телетайп:711).

Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-489-3494
(TTY:711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-855-489-3494 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-489-3494 (TTY:711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-489-3494
(رقم هاتف الصم والبكم: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-489-3494 (ATS :711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-489-3494 (TTY:711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-489-3494 (TTY:711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-489-3494 (TTY:711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-489-3494 (TTY:711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាម៉ែន, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-489-3494 (TTY:711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-489-3494 (TTY:711).