UNITED CONCORDIA

UNITED CONCORDIA LIFE AND HEALTH INSURANCE COMPANY

4401 Deer Path Road
Harrisburg, PA 17110

Dental Plan
Certificate of Insurance

MD9804 B (02/13)

CERTIFICATE OF INSURANCE

INTRODUCTION

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

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

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

800-332-0366

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

www.unitedconcordia.com

Claim forms should be sent to:

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

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Attached:

Appeal Procedure Addendum
Schedule of Benefits
Schedule of Exclusions and Limitations

DEFINITIONS

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

Annual Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during a calendar year or Contract Year as shown on the Schedule of Benefits. Annual Maximums will not apply to essential pediatric dental benefits.

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

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

Certificate of Insurance ("Certificate") - This document, including riders, schedules, addenda and/or endorsements, if any, which describes the coverage purchased from the Company by the Policyholder. A copy of the Certificate will be provided for each Certificate Holder.

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

Company - United Concordia, the insurer.

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

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

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

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

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

Dentally Necessary - A dental service or procedure is determined by a Dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the Dentist and the prevailing standards of care in the professional community. The determination will be made by the Dentist in accordance with guidelines established by the Company. When there is a conflict of opinion between the Dentist and the Company on whether or not a dental service or procedure is Dentally Necessary, the opinion of the Company will be final, subject to the process described in the Appeal Procedure Addendum.

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

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

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

1. The Certificate Holder's Spouse and
2. Any natural child, stepchild, adopted child, grandson/granddaughter, or child placed with the Certificate Holder or the Certificate Holder's Spouse by order of a court or administrative agency:
   (a) until the end of the month that the child reaches age 26; or
   (b) until the end of the month that the child reaches age 26 if he/she is a full-time student at an accredited educational institution and chiefly reliant upon the Certificate Holder for maintenance and support; or
   (c) 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.

A child of a Certificate Holder will not be denied the status of Dependent on the grounds that the child: (a) was born out of wedlock; (b) is not claimed as a dependent on the Certificate Holder's federal income tax return; (c) does not reside with the Certificate Holder or the Company's service area; or (d) is receiving benefits or is eligible to receive benefits under the Maryland Medical Assistance Program.

This Group Policy is a Family Policy. Dependents eligible for coverage in this Family Policy include the Certificate Holder's Spouse.

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

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

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

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

Grace Period - A period of no less than thirty-one (31) days after Premium payment is due under the Group Policy, in which the Policyholder may make such payment and during which the protection of the Group Policy continues. Notice of the intention not to renew will be delivered to the Policyholder at least 45 days prior to the due date of the Premium. During the grace period, the Policy shall remain in force.

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

Lifetime Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during the entire time the Member is enrolled under the Group Policy, as shown on the Schedule of Benefits. Lifetime Maximum(s) will not apply to essential pediatric dental 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.

Maximum Allowable Charge - The maximum amount the Plan will allow for a specific Covered Service. Maximum Allowable Charges may vary depending upon the contract between Us and the particular Participating Dentist rendering the service. Depending upon the Plan purchased by the Policyholder, Maximum Allowable Charges for Covered Services rendered by Non-Participating Dentists may be the same or higher than such charges for Covered Services rendered by Participating Dentists in order to help limit Out-of-Pocket Expenses of Members choosing Non-Participating Dentists.

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

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

Order – A ruling that is issued by a court of this State or another state or an administrative agency of another state; and creates or recognizes the right of a child to receive benefits under a parent's health coverage or establishes a parent's obligation to pay child support and provide health insurance coverage for a child.

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

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

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

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

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

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

Renewal Date - The date on which the Group Policy renews. Also known as anniversary date.

Schedule of Benefits - Attached summary of Covered Services, Plan payment percentages, Deductibles, Waiting Periods and Maximums applicable to benefits payable under the Plan.

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

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

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

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

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

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

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

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

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

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

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

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

Special Enrollment Periods - Enrollment Changes

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

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

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

Except for newly born or adoptive children, coverage for the new Dependent will begin on the first day of the month following the date specified in the enrollment information provided to Us.

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

For an enrolled Dependent child who is a full-time student, evidence of his/her student status and reliance on You for maintenance and support must be furnished to Us within ninety (90) days after the child

attains the limiting age shown in the definition of Dependent. Such evidence will be requested annually thereafter until the Dependent reaches the limiting age for students and his/her coverage ends.

For an enrolled Dependent child who is mentally or physically incapacitated, evidence 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 the child attains the limiting age shown in the definition of Dependent. If the Dependent is a full-time student at an accredited educational institution, the evidence must be provided within thirty (30) days after the Dependent attains the limiting age for students. Such evidence will be requested thereafter based on information provided by the Member's physician, but no more frequently than annually.

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

Continuous open enrollment is available to: (a) Your spouse and children for 6 months after Your spouse loses coverage under another group plan due to involuntary termination of employment (not for cause); and (b) Your children for 6 months after a child loses coverage under Your spouse's group plan due to spouse's death. In addition, if a parent is subject to a court or administrative order creating or recognizing a right of a child to receive benefits under the parent's health insurance coverage, then continuous open enrollment is available to: (a) You and Your Dependent child as to whom the order applies; or (b) the non-insuring parent, the Child Support Enforcement Agency, or the Department of Health and Mental Hygiene for enrollment on behalf of the Dependent child; and the Company will not disenroll or eliminate health insurance coverage for the Dependent child unless written evidence is provided to the Company that: (a) the order is no longer in effect; (b) the child has been or will be enrolled under other reasonable health insurance coverage which will take effect not later than the effective date of the disenrollment; (c) Your Group has eliminated family health coverage; or (d) You are no longer enrolled with Your Group subject, however, to the rights of You and/or Your Dependent child under the Consolidated Omnibus Budget Reconciliation act of 1985 (COBRA)

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 specified in any applicable Late Entrant Rider to the Certificate of Insurance. If You are required by court order to provide coverage for a Dependent child, You will be permitted to enroll the Dependent child without regard to enrollment season restrictions.

HOW THE DENTAL PLAN WORKS

Choice of Provider

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

If You use a Non-Participating Dentist, You may have to pay the Dentist at the time of service, complete and submit Your own claims and wait for Us to make payment to You. You will be responsible for the Dentist's full charge which may exceed Our Maximum Allowable Charge and result in higher Out-of-Pocket Expenses. After application of any deductibles or coinsurances, Plan payment for out-of-network covered services will not be less than 80% of the Plan payment for in-network covered services.

In the following situations, Your benefit for Covered Services at a Non-Participating Dentist will be payable on the same basis as if You visited a Participating Dentist when costs incurred are in excess of the deductible.

1. You require a specialized service; and

2. We confirmed that You do not have access to an appropriately trained Participating Dentist or specialist with the proper expertise, without unreasonable delay or travel.

3. You require a specialized service and We confirmed that we do not have an appropriately trained Participating Dentist or specialist with the proper expertise in Our network.

BENEFITS

Covered Services

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

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

Predetermination

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

Notice of Claim

Written notice of claim must be given to Company within twenty days after the occurrence or commencement of any loss covered by the certificate, or as soon thereafter as is reasonably possible. A claim will not be reduced or invalidated if it was not reasonably possible to provide notice in the stated time, and notice was given as soon as was reasonably possible. Notice given by or on behalf of the Member or the beneficiary, to the Company at the address as noted in the Introduction section of the Certificate or to any authorized agent of the Company, with information sufficient to identify the Member, shall be deemed notice to the Company.

Claims Forms

Company, upon receipt of a notice of claim, will furnish to the Member such forms as are usually furnished by Company for filing claims. If such forms are not furnished within fifteen days after the giving of such notice, the Member shall be deemed to have complied with the required time for filing a claim, upon submitting written proof of the occurrence and a written statement of the nature and extent for which the claim is being made.

Proofs of Loss

Written proof of loss must be furnished to Company at its said office in case of claim for loss for which this Certificate provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the Company is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

Time of Payment of Claims

All benefits payable under this Certificate for any loss other than loss for which this Certificate provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Benefits

If You have treatment performed by a Participating Dentist, We will pay covered benefits directly to the Participating Dentist. Both You and the Dentist will be notified of benefits covered, Our payment and any Out-of-Pocket Expenses. Payment will be based on the Maximum Allowable Charge Your Participating Dentist has contracted to accept. Maximum Allowable Charges may vary depending on the geographical area of the dental office and the contract between Us and the particular Participating Dentist rendering the service.

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

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

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

Overpayments

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

Coordination of Benefits (COB)

If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, benefits will be coordinated. This means that one plan will be primary and determine its benefits before those of the other plan, and without considering the other plan's benefits. The other plan will be secondary and determine its benefits after the primary plan. The secondary plan's benefits may be reduced because of the primary plan's payment. Each plan will provide only that portion of its

benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this Plan will determine payment.

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

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

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

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

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

knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;

2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph 1) above shall determine the order of benefits;
3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph 1) above shall determine the order of benefits; or
4) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    a) First, the plan of the parent with custody of the child.
    b) Second, the plan of the Spouse of the parent with the custody of the child; and
    c) Third, the plan of the parent not having custody of the child.
    d) Finally the plan of the spouse of the parent not having custody of the child.

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

F) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary, and the plan that covered the person for the shorter period of time is secondary.
1) To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.
2) The start of a new plan does not include: A change in the amount or scope of a plan's benefits; A change in the entity that pays, provides or administers the plan's benefits; or A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.
3) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

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

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

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

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

Review of a Benefit Determination

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

TERMINATION -- WHEN COVERAGE ENDS

A Member's coverage will end:

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

If Your coverage or Your Dependents' coverage is terminated as described above, coverage for completion of a dental procedure requiring two or more visits on separate days will be extended for a period of 90 days after the Member's Termination Date in order for the procedure to be finished. This provision includes orthodontic treatment. The procedure must be started prior to the Member's 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, We will provide covered benefits, in accordance with the policy in effect at the time Your coverage terminates, for 60 days after the date coverage terminates if Your provider has agreed to or is receiving monthly payments, or until the later of 60 days after the date coverage terminates or the end of the quarter in progress if Your provider has agreed to accept or is receiving payments on a quarterly basis.

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

If the Policyholder fails to pay Premium, coverage will remain in effect during the Grace Period. If the Premium is not received by the end of the Grace Period, the Group Policy will be cancelled and coverage will terminate. If We do not intend to renew the Policy beyond the period for which Premium has been accepted notice of the intention not to renew will be delivered to the group Policyholder at least 45 days before Premium is due.

Benefits After Coverage Terminates

We are not liable to pay any benefits for services, including those predetermined, that are started after Your Termination Date or after the Group Policy Termination Date. However, coverage for completion of a dental procedure requiring two (2) or more visits on separate days will be extended for a period of ninety (90) days after the Termination Date in order for the procedure to be finished. The procedure must be started prior to the Termination Date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. For orthodontic treatment, if covered under the Plan, coverage will be extended for 60 days after the Member's Termination Date if the orthodontist has agreed to or is receiving monthly payments; or until the later of 60 days after the Member's Termination Date or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis. This extension does not apply if the Group Policy terminates for failure of the Member to pay Premium.

GENERAL PROVISIONS

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

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

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

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

Contestability of Coverage

There will be no contest of the validity of the Group Policy, except for not paying Premiums, after it has been in force two (2) years after the Effective date. No statement made by an insured Member relating to insurability may be used in contesting the validity of the Group Policy after the Member's coverage has been In force before the contest for a period of two (2) years. Absent fraud, all statements made by the Policyholder or by any insured Member shall be deemed representations and not warranties. No statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in writing and signed by the Policyholder and a copy of the statement is furnished to the person or to his beneficiary or personal representative or Group Policyholder.

Legal Actions

No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of sixty days after having been filed in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of three years after the time a claim is required to be filed.

APPEAL PROCEDURE

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

The following contains important information about how to file a Grievance or Appeal. 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. You, Your Authorized Representative, or Your Health Care Provider may submit written comments, documents, records and other information relating to claims or Appeals. You may call Us at 800-332-0366, or write to Us at P.O. Box 69414 Harrisburg PA 17106-9414,. 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, Your Authorized Representative, or Your Health Care Provider.

DEFINITIONS

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

"Appeal" is a protest filed by You, Your Authorized Representative or a Health Care Provider with Us under Our internal appeal process regarding a Coverage Decision.

"Appeal Decision" is a final determination by Us that arises from an Appeal filed with Us under Our Appeal procedure regarding a Coverage Decision.

"Authorized Representative" is a person granted authority to act on Your behalf regarding a claim for benefit or an Appeal of an Coverage Decision. An assignment of benefits is not a grant of authority to act on Your behalf in pursuing an Appeal for an Coverage Decision.

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

"Compelling Reason" means that a delay in receiving the health care service could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ or part, or the Member remaining seriously mentally ill with symptoms that cause the member to be in danger to self or others.

"Complaint" is a protest filed with the Commissioner involving a Coverage Decision or a Grievance Decision.

"Coverage Decisions" is:

1. The initial determination by Us resulting in non-coverage of a dental care service;
2. The determination by Us that You are not eligible for coverage.
3. A determination by Us that results in a rescission of coverage.

For utilization review determinations based on Dental Necessity or appropriateness, see the Grievance Procedure in this Addendum. A Coverage Decision is not an Adverse Decision.

"Health Care Provider" is an individual who is licensed under the Health Occupations Article to provide health care services in the ordinary course of business or practices of a profession and is a treating provider of the Member or a Hospital.

"Hospital" means an institution that: has a group of at least five (5) physicians who are organized as a medical staff for the institution; maintains facilities to provide, under the supervision of the medical staff, diagnostic and treatment services for two (2) or more unrelated individuals; and admits or retains the individuals for overnight care.

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

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

"Urgent Medical Condition" is a condition that satisfies either of the following:

1. A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within seventy-two (72) hours could reasonably be expected by an individual, acting on behalf of a carrier, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
   a. Placing the Member's life or health in serious jeopardy;
   b. The inability of the Member to regain maximum function;
   c. Serious impairment to bodily function;
   d. Serious dysfunction of any bodily organ or part; or
   e. The Member remaining seriously mentally ill with symptoms that cause the Member to be a danger to self or others; or
2. A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within seventy-two (72) hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Coverage Decision.

PROCEDURE FOR PRE-SERVICE CLAIM

You, Your Health Care Provider, or Your Authorized Representative may file an Appeal with Us upon the receipt of an Coverage Decision. 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 thirty (30) working days of the request for an Appeal. Within thirty (30) calendar days after a Coverage Decision has been made, We will send a written notice of the Coverage Decision to You or Your Authorized Representative, and the treating provider.

The notice of Coverage Decision from Us shall include:

1. the specific factual basis for Our decision in detailed and clear, understandable language.
2. a statement that the You, Your Health Care Provider, or Your Authorized Representative has a right to file an Appeal with Us. Our internal appeal process must be exhausted before You may file a Complaint with the Commissioner of Insurance.
3. a statement that You, Your Health Care Provider, or Your Authorized Representative may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves an urgent medical condition for which care has not been rendered. The Commissioner's address is as follows:

Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000 or 800-492-6116
Fax: 410-468-2270

4. a statement that the Health Advocacy Unit is available to assist You in both mediating and filing an Appeal under Our internal appeal process. You may contact the Health Advocacy Unit at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or toll-free: 877-261-8807
Fax: 410-576-6571
Email: heau@oag.state.md.us
Website: http://www.oag.state.md.us

Procedure for Post-Service Claim

You, Your Health Care Provider, or Your Authorized Representative may file an Appeal with Us upon the receipt of an Coverage Decision. 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 thirty (30) working days of the request for an Appeal. Within thirty (30) calendar days after a Coverage Decision has been made, We will send a written notice of the Coverage Decision to You or Your Authorized Representative, and the treating provider.

The notice of Coverage Decision from Us shall include:

1 the specific factual basis for Our decision in detailed and clear, understandable language.
2. a statement that the You, Your Health Care Provider, or Your Authorized Representative has a right to file an Appeal with Us. Our internal appeal process must be exhausted before You may file a Complaint with the Commissioner of Insurance.
3. a statement that You, Your Health Care Provider, or Your Authorized Representative may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves an urgent medical condition for which care has not been rendered. The Commissioner's address is as follows:

Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000 or 800-492-6116
Fax: 410-468-2270

4. a statement that the Health Advocacy Unit is available to assist You in both mediating and filing an Appeal under Our internal appeal process. You may contact the Health Advocacy Unit at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or toll-free: 877-261-8807
Fax: 410-576-6571
Email: heau@oag.state.md.us
Website: http://www.oag.state.md.us

Appeals Procedure

You may request reconsideration of a Coverage Decision by submitting a written Appeal to Us. We will reconsider the Coverage Decision. The Appeal will be reviewed and a final decision rendered. The final decision will be in writing to You or Your Authorized Representative and the Health Care Provider, within sixty (60) working days after the date on which the Appeal is filed.

The final decision will include a written notice of the Appeal decision. Written notice of the Appeal decision will be sent within thirty (30) calendar days of the Appeal decision to You or Your Authorized Representative and the Health Care Provider acting on Your behalf. The notice of the Appeal decision shall include the following:

a. the specific factual basis for Our decision in detailed and clear, understandable language.
b. that You, Your Health Care Provider, or Your Authorized Representative has a right to file a Complaint with the Commissioner within four (4) months after receipt of Our Appeal decision, including the contact information as indicated above.
c. a statement that You, Your Health Care Provider, or Your Authorized Representative may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves an urgent medical condition for which care has not been rendered. The Commissioner's address is as follows:

Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000 or 800-492-6116
Fax: 410-468-2270

d. a statement that the Health Advocacy Unit is available to assist You in both mediating and filing an Appeal under Our internal appeal process. You may contact the Health Advocacy Unit at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or toll-free: 877-261-8807
Fax: 410-576-6571
Email: heau@oag.state.md.us
Website: http://www.oag.state.md.us

Grievance Procedure

If You are dissatisfied with Our Adverse Decision on a claim, You may Appeal Our decision by following the steps outlined in this Grievance procedure. We will resolve Your Grievance in a thorough, appropriate, and timely manner to ensure that You are afforded a full and fair review of claims for benefits. You, Your Health Care Provider, or Your Authorized Representative may submit written comments, documents, records and other information relating to claims or Grievances. You may call Us at (800) 772-1133, or write to Us at P.O. Box 69420 Harrisburg PA 17106-9420. We will provide a review that takes into account all information submitted whether or not it was considered with Our first determination on the claim. Any notifications by Us required under these procedures will be supplied to You, Your Health Care Provider, or Your Authorized Representative.

Definitions

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

"Adverse Decision" means a utilization review determination based on Dental Necessity or appropriateness that results in a determination that the service is not covered by this Plan.

"Authorized Representative" is a person granted authority by You to act on Your behalf regarding a claim for benefit or Grievance of an Adverse Decision. An assignment of benefits is not a grant of authority to act on Your behalf in appealing a benefit determination.

"Compelling Reason" means that a delay in receiving the health care service could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ or part, or the Member remaining seriously mentally ill with symptoms that cause the member to be in danger to self or others.

"Complaint" means a protest filed with the Commissioner involving an Adverse Decision or Grievance Decision concerning the Member.

"Dental Necessity" means a dental service or procedure is determined by a dentist to either establish or maintain a Member'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 Us. When there is a conflict of opinion between the dentist and Us on whether or not a dental service or procedure is Dentally Necessary, Our opinion will be final. You or Your Health Care Provider may contact Us at (800) 772-1133 if You have any questions regarding a Dental Necessity request.

"Emergency Case" means: (a) an adverse decision is rendered for a dental service or procedure that is proposed but has not been delivered; and (b) the dental service or procedure is necessary to treat a condition or illness that, without immediate medical attention, would seriously jeopardize Your life or health or Your to regain maximum function, or cause You to be in danger to self or others.

"Filing Date" means the earlier of five (5) days after the mailing or the date of receipt.

"Grievance" means a protest filed by the Member, Your Authorized Representative or a Health Care Provider on behalf of a Member with Us through Our Grievance procedure regarding an Adverse Decision.

"Grievance Decision" means a final determination by Us that arises from a Grievance filed with Us through Our Grievance procedure regarding an Adverse Decision.

"Health Care Provider" means an individual who is licensed under the Health Occupations Article to provide health care services in the ordinary course of business or practices of a profession and is a treating provider of the Member or a Hospital.

"Hospital" means an institution that: has a group of at least five (5) physicians who are organized as a medical staff for the institution; maintains facilities to provide, under the supervision of the medical staff, diagnostic and treatment services for two (2) or more unrelated individuals; and admits or retains the individuals for overnight care.

Maryland Notification Procedure

For an Emergency Case We will send an Adverse Decision Notice You, Your representative, or Your Health Care Provider within twenty-four (24) hours after the Adverse Decision is made. The Adverse Decision notice shall include:

1. the specific factual basis for Our decision in detailed and clear, understandable language.

2. references to the specific criteria, including interpretive guidelines on which the Dental Necessity decision was based. The notice will not solely use generalized terms such as “experimental procedure not covered”, “cosmetic procedure not covered’, “service included under another procedure” or “not Dentally Necessary.”
3. written details of Our internal Grievance process and how to file a Grievance with Us. The notice will include the name, address, and telephone number of an individual You may contact who is responsible for Our Grievance process.
4. a statement that You, Your Health Care Provider, or Your Authorized Representative has the right to file a Complaint with the Commissioner within four (4) months after receipt of Our Grievance Decision.
5. a statement that You, Your Health Care Provider, or Your Authorized Representative may file a Complaint with the Commissioner without first filing a Grievance if You can demonstrate a compelling reason to do so, and it’s contact information, as indicated above.
6. a statement that the Health Advocacy Unit is available to assist You or Your Authorized Representative in both mediating and filing a Grievance under Our internal Grievance procedure, and it’s contact information, as indicated above.

For a nonemergency case we will document the Adverse Decision in writing after We have provided oral communication of the decision to You, Your Authorized Representative, or Your Health Care Provider. We will send within five (5) working days after the Adverse Decision has been made, a written notice to You or Your Authorized Representative and Your Health Care Provider which shall include:

1. the specific factual basis for Our decision in detailed and clear, understandable language.
2. references to the specific criteria, including interpretive guidelines on which the Dental Necessity decision was based. The notice will not solely use generalized terms such as “experimental procedure not covered”, “cosmetic procedure not covered’, “service included under another procedure” or “not Dentally Necessary.”
3. written details of Our internal Grievance process and how to file a Grievance with Us. The notice will include the name, address, and telephone number of an individual You may contact who is responsible for Our Grievance process.
4. a statement that You, Your Health Care Provider, or Your Authorized Representative has the right to file a Complaint with the Commissioner within four (4) months after receipt of Our Grievance Decision.
5. a statement that You, Your Health Care Provider, or Your Authorized Representative may file a Complaint with the Commissioner without first filing a Grievance if You can demonstrate a compelling reason to do so, and it’s contact information, as indicated above.
6. a statement that the Health Advocacy Unit is available to assist You or Your Authorized Representative in both mediating and filing a Grievance under Our internal Grievance procedure, and it’s contact information, as indicated above.

Maryland Grievance Procedure

You, Your Health Care Provider, or Your Authorized Representative may file a Grievance with Us no later than one-hundred-eighty (180) days after the receipt of an Adverse Decision. To file a Grievance, contact Us at:

Dental Advisor - Maryland Grievance
United Concordia Companies, Inc.
P.O. Box 69420
Harrisburg, PA 17106
Phone: 1-800-772-1133

For Emergency Cases

If We do not have sufficient information to review Your Grievance, We will notify You, Your Authorized Representative, or Your Health Care Provider within twenty four (24) hours of the filing date that We cannot proceed with the review of the Grievance unless additional information is provided. We will assist You or Your Authorized Representative in gathering the necessary information to review the Grievance

Within twenty-four (24) hours after the filing date, We will render a final decision and will send a written notice of the Grievance Decision to You or Your Authorized Representative and the treating provider. We will document the Grievance Decision in writing after We have provided oral communication of the decision to You, Your Authorized Representative, or Your Health Care Provider. We will send within twenty four (24) hours after the Grievance Decision has been made, a written notice to You or Your Authorized Representative and Your Health Care Provider which shall include:

1. the specific factual basis for Our decision in detailed and clear, understandable language.
2. references to the specific criteria, including interpretive guidelines on which the Dental Necessity decision was based.
3. the name, address, and telephone number of an individual You may contact who is responsible for Our Grievance process.
4. a statement that the Member, Health Care Provider, or Authorized Representative may file a Complaint with the Commissioner within four (4) months after receipt of Our Grievance Decision, including the right to file a Complaint with the Commissioner without first exhausting Our internal Appeals process if a) We agree to waive this requirement or b) We have failed to comply with any of the requirements of the internal Grievance process or c) You, Your Authorized Representative or Your Health Care Provider provide sufficient documentation to demonstrate a compelling reason to do so. We will include the Commissioner's contact information, as indicated above.
5. a statement that the Health Advocacy Unit is available to assist You or Your Authorized Representative in filing a Complaint with the Commissioner, including the Health Advocacy Unit's contact information, as indicated above.

<u>For nonemergency cases</u>

If We do not have sufficient information to review Your Grievance, We will notify You, Your Authorized Representative, or Your Health Care Provider within five (5) working days of the filing date that We cannot proceed with the review of the Grievance unless additional information is provided. We will assist You or Your Authorized Representative in gathering the necessary information to review the Grievance.

We will render a final decision and will send a written notice of the Grievance Decision to You or Your Authorized Representative and the treating provider within forty-five (45) working days after the filing date for a retrospective denial, and within thirty (30) days after the filing date for a prospective denial. These time frames may be extended an additional thirty (30) with Your, Your Authorized Representatives, or Your Health Care Providers written approval.

We will document the Grievance Decision in writing after We have provided oral communication of the decision to You, Your Authorized Representative, or Your Health Care Provider. We will send within five (5) working days after the Grievance Decision has been made, a written notice to You or Your Authorized Representative and Your Health Care Provider which shall include:

1. the specific factual basis for Our decision in detailed and clear, understandable language.
2. references to the specific criteria, including interpretive guidelines on which the Dental Necessity decision was based.
3. the name, address, and telephone number of an individual You may contact who is responsible for Our Grievance process.
4. a statement that the Member, Health Care Provider, or Authorized Representative may file a Complaint with the Commissioner within four (4) months after receipt of Our Grievance Decision, including the right to file a Complaint with the Commissioner without first exhausting Our internal Appeals process if a) We agree to waive this requirement or b) We have failed to comply with any of the requirements of the internal Grievance process or c) You, Your Authorized Representative or Your Health Care Provider provide sufficient documentation to demonstrate a compelling reason to do so. We will include the Commissioner's contact information, as indicated above.
5. a statement that the Health Advocacy Unit is available to assist You or Your Authorized Representative in filing a Complaint with the Commissioner, including the Health Advocacy Unit's contact information, as indicated above.

If the grievance decision is not received You may file a Complaint with the Commissioner within:

1. twenty-four (24) hours after filing the grievance for emergency cases;
2. thirty (30) working days after the grievance filing date for prospective cases, and.
3. forty-five (45) working days after the grievance filing date for retrospective cases.

For urgent Medical Conditions or an Emergency Case, We do not require prior authorization of services and We do not render Adverse Decisions related to care of the same.

United Concordia Life and Health Insurance Company

Authorized Officer

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

ADDENDUM

TO

GROUP POLICY AND CERTIFICATE OF INSURANCE

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

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

> The Company uses Maximum Allowable Charge schedules to determine claim payments. Payment is the lesser of the dentist's submitted charge or the Maximum Allowable Charge.
>
> Maximum Allowable Charges for Covered Services are determined by geographical area of the dental office. The Maximum Allowable Charges in the geographical area of the dental office are used to calculate the Company• s payment on claims. Maximum Allowable Charges are reviewed periodically and adjusted as appropriate to reflect increased dentist fees within the geographical areas. Participating Dentists accept their contracted Maximum Allowable Charges as payment in full for Covered Services.

UNITED CONCORDIA LIFE AND HEALTH
INSURANCE COMPANY

_____
Authorized Officer

Schedule of Benefits

Concordia Choice

Group Name: Ollies Bargain Outlet Inc
Group Number:* 843767000** ***Effective Date: July 1, 2016

	Plan Pays
Class I Services	
• Exams	**100%**
• Bitewing X-Ray	**100%**
• Cleanings & Fluoride Treatments	**100%**
Class II Services	
• All Other X-Rays	**80%**
• Sealants	**80%**
• Palliative Treatment (Emergency)	**80%**
• Space Maintainers	**80%**
• Basic Restorative (Fillings, etc.)	**80%**
• Simple Extractions	**80%**
Class III Services	
• Endodontics	**50%**
• Non-Surgical Periodontics	**50%**
• Repairs of Crowns, Inlays, Onlays	**50%**
• Repairs of Bridges	**50%**
• Denture Repairs	**50%**
• Surgical Periodontics	**50%**
• Complex Oral Surgery	**50%**
• General Anesthesia	**50%**
• Inlays, Onlays, Crowns	**50%**
• Prosthetics (Bridges, Dentures)	**50%**
Orthodontics	
• Diagnostic, Active, Retention Treatment	**0%**

Deductibles & Maximums

- *$50 per Contract Year Deductible per Member (excluding Class I Services) not to exceed $150 per family*
- *$1000 per Contract Year Maximum per Member*

All services on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations. Consult Your Certificate for more details on the services listed.

Participating Dentists accept the Maximum Allowable Charge as payment in full.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

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

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

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

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (for example but not limitation, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).
3. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12. For treatment of malignancies or neoplasms.

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

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

15. Preventive restorations.

16. Periodontal splinting of teeth by any method.

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

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

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

20. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

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

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

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

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

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

24. Procedures that are:

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

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

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

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

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

14. Recementation – one (1) per 12 months. Recementation during the first 12 months following insertion of any preventive, restorative or prosthodontic service by the same dentist is included in the preventive, restorative or prosthodontic service benefit.
15. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.
16. Payment for orthodontic services shall cease at the end of the month after termination by the Company.

    This limitation does not apply to Group Policies issued and delivered in Maryland.

17. Intraoral Films:
    - Occlusal – two (2) per 24 months under age eight (8).
18. General anesthesia and IV sedation: a total of sixty 60 minutes per session.

United Concordia

Rider to Schedule of Benefits

Preventive Incentive®

This Rider is effective on July 1, 2016 and is attached to and made a part of the Schedule of Benefits.

Benefits for the following services shown as covered on the Schedule of Benefits will not be counted toward accumulation of the program Maximum indicated on the Schedule of Benefits:

- Exams
- Bitewings X-Ray
- Cleanings (routine prophylaxis)
- Fluoride Treatments

United Concordia

Smile for Health - Wellness Rider

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

DEFINITIONS

The following definition applies when used in this Rider.

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

ELIGIBILITY

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

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

- Member received head and/or neck radiation therapy in the 60 months prior to the date this condition is reported to the Company.

- Member received an organ transplant in the 60 months prior to the date this condition is reported to the Company.

SCHEDULE OF BENEFITS

Plan Payment

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

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

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

- Gingival flap procedures;
- Osseous surgeries.

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

- Periodontal cleanings;
- Periodontal scaling and root planing.

Applicability of Plan Payments, Deductibles, Maximums and Waiting Periods

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

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

Frequency Limitations

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

- Periodontal cleanings following active periodontal therapy;

Applicability of Limitations and Exclusions

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

GENERAL

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

DAVIS VISION *Benefits You Can See*

1. DISCOUNT PROGRAM

Davis Vision is pleased to provide you with a low-cost, traditional vision Discount Program that provides significant discounts on eye exams, lenses, frames and additional eyewear options. Simply visit a participating vision provider and present your discount card and Control Code. With nearly 26,000 participating vision providers, you can find a provider near you by calling our toll-free Interactive Voice Response (IVR) system or visiting the Davis Vision website at **www.davisvision.com**. For more details, see the Accessing Benefit and Provider Information section on the reverse side.

The Discount Program entitles you to the following discounts off usual and customary fees:

Vision Plan:	Vantage Affinity Discount Program
Control Code/Client Control Number:	7602
Co-payment:	N/A, discount plan is 100% member paid at the time of service
Lens 123®:	Discounts on replacement contact lenses from 1-800-LENS123
Laser Vision Correction:	Discounts from participating laser vision providers

DAVIS VISION DISCOUNT SCHEDULE	MEMBER COST
Eye examination	
Complete Examination	15% off Usual & Customary
Contact Lens Examination	15% off Usual & Customary
Frame	
Frame—up to $70.00 retail	$40.00
Frame—over $70.00 retail	$40.00 plus 10% off the amount over $70.00
Spectacle Lenses	
Single Vision Lenses	$35.00
Bifocal Lenses	$55.00
Trifocal Lenses	$65.00
Lenticular Lenses	$110.00
Options (Add to Spectacle Lenses Prices)	
Standard Progressive Lenses	$75.00
Premium Progressive Lenses	$125.00
Polarized	$75.00
High Index Lenses	$55.00
Glass Lenses	$18.00
Polycarbonate Lenses	$30.00
Blended Invisible Bifocals	$20.00
Intermediate Vision Lenses	$30.00
Scratch Resistant Coating	$15.00
Anti-Reflective Treatment	$45.00
Ultraviolet Coating	$15.00
Solid Tint	$10.00
Gradient Tint	$12.00
PGX Lenses	$35.00
Plastic Photosensitive Lenses	$65.00
Contact Lenses	
Conventional	20% off Usual & Customary
Disposable/Planned Replacement	10% off Usual & Customary
Lens 123®	Free membership with up to 60% off Retail Prices

Discount Schedule continued . . .

DAVIS VISION™
THE EYECARE ADVANTAGE

This card entitles the bearer and family to special discounted pricing

Name _____

Group United Concordia

Control Code 7602

Signature _____

Benefits you can see.

Discount Schedule continued . . .

Other Products

Non-Prescription Sunglasses	20% off Usual & Customary
Other Ancillary Products/Solutions	10% off Usual & Customary
Laser Vision Correction	Up to 25% off Usual & Customary

Note: Any special lens designs, materials, powers and frames may require additional payment.

2. LENS 123®

Lens 123® is a mail order program that allows you to enjoy the guaranteed lowest prices on replacement contact lenses—save up to 60% off retail prices. Members can conveniently call 1-800-LENS123 with a current prescription for this value-added service. The Lens 123® contact lens replacement program is endorsed by the industry's major manufacturers.

3. LASER VISION CORRECTION

Davis Vision's Laser Vision Correction program provides substantial discounts on laser vision correction procedures. Members are entitled to savings of up to 25% off usual and customary fees or a 5% discount off a center's advertised special through a network of preeminent physicians affiliated with Eye Centers of Excellence. (Some centers provide a flat fee equating to these discount levels.) See below for information on finding a participating laser vision provider near you.

HOW THE DISCOUNT PROGRAM WORKS WITH YOUR PLAN

You may choose from a list of Davis Vision contracted private practice providers or contracted retail locations for discounts on eyewear. If you already have a vision examination benefit as part of your health plan, you may use a network provider in your health plan network for your examination. Then use a Davis Vision contracted provider for your eyewear purchases (eyeglasses, etc.) and maximize your savings (you should verify whether or not the Davis Vision provider accepts outside prescriptions prior to your appointment).

ACCESSING BENEFIT AND PROVIDER INFORMATION

Whether you're looking for a participating vision provider or want more information about the discount plan, Davis Vision offers a number of convenient ways for you to get the information you need, when you need it.

AUTOMATED SERVICES (available 24/7)

Online—To access the United Concordia Davis Vision Discount Member Menu, visit **www.davisvision.com** and select "Find a Provider". In the second box, enter Control Code 7602 and click "Submit". From the Member Menu you can find a provider, review your benefits, obtain a confirmation number for laser surgery, take a satisfaction survey, visit Lens 123® to buy replacement contact lenses and more!

Over the phone—To access the automated Interactive Voice Response (IVR) system, call Davis Vision Customer Service at **1-877-923-2847** and enter Client Control Number 7602 when prompted. Select the appropriate menu option using your phone's touch pad.

CUSTOMER SERVICE

To speak with a customer service representative, call Davis Vision Customer Service at 1-877-923-2847. Enter Client Control Number 7602 when prompted. At the main menu, press "0". Our representatives are available to assist you from 8 a.m. to 11 p.m. ET Monday through Friday, 9 a.m. to 4 p.m. ET Saturday and 12 p.m. to 4 p.m. ET Sunday.

DAVIS VISION™
THE EYECARE ADVANTAGE

CUSTOMER SERVICE
1-877-923-2847

UNITED CONCORDIA
Insuring America's Dental Health

CAERE03/06 • Available Concordia products are underwritten by United Concordia Insurance Company in OK and written on OK policy forms 9802 (06/01) and 9802L (06/01).