

UNITED CONCORDIA

4401 Deer Path Road
Harrisburg, PA 17110

Dental Plan Certificate of Insurance

Network Plan

Cobb County Government
A05084000
January 1, 2015

Benefits may vary for services rendered by a Preferred Dentist.
See the Schedule of Benefits for coverage details.

You may contact (800) 332-0366 or visit www.unitedconcordia.com
to obtain the name of a Preferred Dentist.

In AL, United Concordia is underwritten by
United Concordia Dental Corporation of Alabama

In AK, AR, AZ, CA, CO, CT, FL, GA, IA, ID, IN, KS, LA, MA, MD, ME, MN, MI, MS,
MT, NE, NV, NH, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WV, WY,
United Concordia is underwritten by
United Concordia Insurance Company

In DE, DC, IL, KY, MD, MO, NC, NJ, PA, United Concordia is underwritten by
United Concordia Life and Health Insurance Company

In NY, United Concordia is underwritten by
United Concordia Insurance Company of New York

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

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 69444
Harrisburg, PA 17106-9444

TABLE OF CONTENTS

DEFINITIONS 3
ELIGIBILITY AND ENROLLMENT 5
HOW THE DENTAL PLAN WORKS..... 9
BENEFITS 10
TERMINATION 13
CONTINUATION OF COVERAGE 13
GENERAL PROVISIONS 14

Attached:

- Appeal Procedure Addendum
- State Law Provisions Addendum
- Schedule of Benefits
- Schedule of Exclusions and Limitations

DEFINITIONS

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

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

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

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

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

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

Company - United Concordia, the insurer.

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

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

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

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

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

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

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

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

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

1. The Certificate Holder's spouse; and
2. Any natural child, stepchild, adopted child or child placed with the Certificate Holder or the Certificate Holder's Spouse by order of a court or administrative agency:
 - (a) until the end of the month that the child reaches age 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 is 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.

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. Drug usage that has not been approved by the Federal Food and Drug Administration for a particular indication and is recognized for treatment of the indication in at least one standard compendium shall not be considered Experimental or Investigative.

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, subject to payment of Premium by the end of the Grace Period.

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

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

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

Maximum Allowable Charge - The Maximum Allowable charge for all services, including treatment for dental emergencies, to a Non-Preferred Dentist will be equal to or greater than Maximum Allowable charge to a Preferred Dentist.

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

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

Out-of-Pocket Expense(s) – Costs not paid by Us, including but not limited to Coinsurance, Deductibles, amounts billed by Non-Preferred 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.

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.

Preferred Dentist – A dentist who has executed a Participating Dentist Agreement with the Company or an affiliate of the Company, under which he/she agrees to accept the Company’s Maximum Allowable Charges as payment in full for Covered Services.

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

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

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

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

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

State Law Provisions Addendum – Attached document, if any, containing state law requirements that modify, delete, and/or add provisions to the Certificate of Insurance.

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

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

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

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

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

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

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

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

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

Special Enrollment Periods - Enrollment Changes

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

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

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

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

- state of residence;
- incarceration status;
- citizenship, status as a national or lawful presence;
- income, except when You did not request from the Authorized Entity an eligibility determination for insurance affordability programs.

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

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

Newly born children of a Member will be considered enrolled from the moment of birth. Adoptive children will be considered enrolled from the date of adoption or placement, except for those adopted or placed within thirty-one (31) days of birth who will be considered enrolled Dependents from the moment of birth.

In order for coverage of newly born or adoptive children to continue beyond the first thirty-one (31) day period, the child's enrollment information must be provided to Us and the required Premium must be paid within the 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 handicapped, 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 or when otherwise permitted by any applicable law or regulation intended to implement the federal Affordable Care Act.

Late Enrollment

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

HOW THE DENTAL PLAN WORKS

Choice of Provider

You may choose any licensed Dentist for services. However, Your Out-of-Pocket Expenses will vary depending upon whether or not Your Dentist is in Our network. If You choose a Preferred Dentist, You may limit Your Out-of-Pocket Expense. Preferred Dentists agree by contract to accept Maximum Allowable Charges as payment in full for Covered Services. Also, if agreed by the provider, Preferred 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. Preferred Dentists also complete and send claims directly to Us for processing. To find a Preferred 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- Preferred Dentist, You may have to pay the Dentist at the time of service, complete and submit Your own claims and wait for Us to reimburse You. You will be responsible for the Dentist's full charge which may exceed Our Maximum Allowable Charge and result in higher Out-of-Pocket Expenses.

Notice of Claim

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

Claim Forms

The Company, upon receipt of a notice of claim, will furnish to the Member such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 10 days after the Company received notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

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

Proof of Loss

Written proof of loss must be furnished to the Company at its said office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 30 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.

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

Time Payment of Claims

All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid no later than 30 days and acknowledge no later than 15 days from receipt

of due written proof of such loss. The Company may extend this 30-day period by no more than 15 days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Company. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid quarterly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. Benefits not paid in accordance with this provision, Company shall pay 18 percent per annum on the proceeds overdue under the Plan for benefits not paid in accordance with this provision.

Physical Examinations

The Company at its own expense shall have the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of a claim hereunder.

BENEFITS

Covered Services

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

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

Predetermination

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

Payment of Benefits

If You have treatment performed by a Preferred Dentist, We will pay covered benefits directly to the Preferred 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 Preferred 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 Preferred Dentist rendering the service.

If You receive treatment from a Non- Preferred 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- Preferred 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- Preferred Dentists are not obligated to limit their fees to Our Maximum Allowable Charges.

We are not liable to pay benefits for any services started prior to a Member's Effective Date of coverage. Multi-visit procedures are considered "started" when the teeth are irrevocably altered. For example, for

crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. Procedures started prior to the Member's Effective Date are the liability of the Member.

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

Overpayments

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

Coordination of Benefits (COB)

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

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

- A) If the other plan does not have a provision similar to this one, then that plan will be primary.
 - B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.
 - C) Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:
 - 1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
 - 2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
 - 3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
 - 4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
 - D) Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - 1) First, the plan of the parent with custody of the child.
 - 2) Then, the plan of the Spouse of the parent with the custody of the child; and
 - 3) Finally, the plan of the parent not having custody of the child.
 - 4) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
 - 5) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 3-C) above, titled Dependent Child/Parents Not Separated or Divorced.
 - E) Active/Inactive Member
 - 1) For actively employed Members and their Spouses over the age of sixty-five (65) who are covered by Medicare, the plan will be primary.
 - 2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.
 - F) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary.
 - G) The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a Member or a Dependent.
4. Right to Receive and Release Needed Information -- Certain facts are needed to apply these COB rules. The Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Any health information furnished to a third party will be released in accordance with federal law. Each person claiming benefits under This Plan must give any facts needed to pay the claim.
5. Facility of Payment -- A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Company may pay the amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan, and the Company will not pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the services prepaid by the Company.

Review of a Benefit Determination

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

Value-Added Programs and Services

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

TERMINATION -- WHEN COVERAGE ENDS

A Member's coverage will end:

- when You no longer meet Your Group's eligibility requirements; or
- when Premium payment ceases for You; or
- when you no longer meet the eligibility requirements for a Dependent, as defined in the Definitions section of this Certificate; or
- when You no longer meet other eligibility requirements imposed by an Authorized Entity; or
- on the termination date specified for You by Authorized Entity.

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

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

Benefits After Coverage Terminates

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

CONTINUATION COVERAGE

Federal or state law may require that certain employers offer continuation coverage to Members for a period of time upon the Certificate Holder's reduction of work hours or termination of employment for any reason other than gross misconduct. Contact Your Group to find out if this applies to You. Your Group will advise You of Your rights to continuation coverage and the cost. If applicable, You must elect to continue coverage within sixty (60) days from Your qualifying event or from notification of rights by Your

Group, whichever is later. Dependents may have separate election rights, or You may elect to continue coverage for them. You must pay the required premium for continuation coverage directly to Your Group. The Company is not responsible for determining who is eligible for continuation coverage.

GENERAL PROVISIONS

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

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

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

This Certificate will be construed for all purposes as a legal document and will be interpreted and enforced in accordance with pertinent laws and regulations of the state indicated on the State Law Provisions Addendum.

Legal Actions

No action at law or inequity shall be brought to recover on this Certificate prior to the expiration of 60 days after a claim has been filed in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of 3 years after the time a claim is required to be filed.

Right of Recovery

If You or Your covered Dependent has a claim for damages or a right to recover damages from a third party or parties for any illness or injury for which benefits are payable under this Plan, the Company may have a right of recovery. Our right of recovery shall be limited to the recovery of any benefits paid for identical Covered Services under this Plan, but shall not include non-dental items. Money received for future dental care or pain and suffering may not be recovered. The Company's right of recovery may include compromised settlements. You or Your attorney must inform the Company of any legal action or settlement agreement at least 10 days prior to settlement or trial. The Company will notify You of the amount it seeks to recover for covered benefits paid. Our recovery may be reduced by the pro-rata share of Your attorney's fees and expenses of litigation.

ADDENDUM TO CERTIFICATE

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.

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

DEFINITIONS

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

“Adverse Benefit Determination” is a denial, reduction, or termination of or failure to make payment (in whole or in part) for a Claim for Benefits based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is Experimental or Investigational, not Dentally Necessary, not Medically Necessary or not appropriate.

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

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

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

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

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

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

PROCEDURE FOR PRE-SERVICE CLAIM

You or Your Authorized Representative have 180 days from the date You or Your Authorized Representative received notice of the Adverse Benefit Determination to appeal the decision. To file an appeal, call the toll-free telephone number listed in Your Certificate of Coverage or on Your ID card.

The dentist advisor involved in the appeal will be different from and not a subordinate of the dentist advisor involved in the adverse determination on initial Claim for Benefits. We will provide You or Your Authorized Representative with written or electronic notice of Our appeal decision within 30 days of the request to review the Adverse Benefit Determination. The notice of Our appeal decision will include the following:

- a) The specific reason for the appeal decision;
- b) A reference to specific plan provisions on which the decision was based;
- c) A statement that You or Your Authorized Representative is entitled reasonable access to and copies of all relevant documents, records, and criteria. This includes an explanation of clinical judgment on which the decision was based and identification of the dental experts. All such information is available upon request and is free of charge.
- d) A statement of Your or Your Authorized Representative's right to bring a civil action under ERISA; and
- e) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

PROCEDURE FOR POST-SERVICE CLAIM

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

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

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

- a) the specific reason for the appeal decision;
- b) reference to specific plan provisions on which the decision was based;
- c) a statement that You are entitled to receive reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts; All such information is available upon request and is free of charge.
- d) a statement of Your right to bring a civil action under ERISA; and
- e) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
- f) The option of seeking an independent review through a certified independent review agent if the service is greater than \$500.00.

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:

In-Network Maximum Allowable Charges for Covered Services are determined by geographical area of the dental office. The In-Network Maximum Allowable Charges in the geographical area of the dental office are used to calculate the Company's payment on claims. Preferred Dentists accept their contracted Maximum Allowable Charges as payment in full for Covered Services. Out-of-Network Maximum Allowable Charges are determined as a percentile of dentist charges for Covered Services by grouping the 90th percentile of dentist charges into different geographical areas. Non-preferred Dentists may bill You for charges exceeding the Out-of-Network Maximum Allowable Charge paid by the Company. The Out-of-Network Maximum Allowable Charges at the indicated percentile in the geographical area of the dental office are used to calculate the Company's payment on Non-Preferred Dentist claims. Maximum Allowable Charges are reviewed periodically and adjusted as appropriate to reflect increased dentist fees within the geographical areas. The source of the dentist charge data for Out-of-Network Maximum Allowable charge calculation is select charge data purchased by the Company and supplemented where necessary by internal claim data.

United Concordia Insurance Company



Authorized Officer

Schedule of Benefits

Concordia Flexsm

Group Name: Cobb County Government
Group Number: A05084000

Effective Date: January 1, 2015

	<u>Plan Pays</u>
<i>Class I Services</i>	
• Exams	100%
• All X-Rays	100%
• Cleanings & Fluoride Treatments	100%
• Sealants	100%
• Palliative Treatment (Emergency)	100%
<i>Class II Services</i>	
• Space Maintainers	80%
• Basic Restorative (Fillings, etc.)	80%
• Endodontics	80%
• Non-Surgical Periodontics	80%
• Repairs of Crowns, Inlays, Onlays	80%
• Repairs of Bridges	80%
• Denture Repair	80%
• Simple Extractions	80%
• Surgical Periodontics	80%
• Complex Oral Surgery	80%
• General Anesthesia	80%
<i>Class III Services</i>	
• Inlays, Onlays, Crowns	50%
• Prosthetics (Bridges, Dentures)	50%
<i>Orthodontics</i>	
• Diagnostic, Active, Retention Treatment	0%
<u>Deductibles</u>	
Deductible per Member per Calendar Year	For Covered Services \$50 not to exceed \$150 per family.
Services waived from the Deductible	waived Class I Services
<u>Maximums</u>	
Maximum per Member per Calendar Year	For Covered Services \$1000

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.

The Plan pays the indicated percentage of the Maximum Allowable Charge in the "Plan Pays" column. Preferred Dentists accept the Maximum Allowable Charge as payment in full. Any difference between the Plan's payment and the Non-Preferred Dentist's charge is the Member's responsibility to pay.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

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

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

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

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

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

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

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

4. For prescription and non-prescription drugs, vitamins or dietary supplements.

For Group Policies issued and delivered in Arizona and New Mexico, this exclusion does not apply.

5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.

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

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

6. Which are Cosmetic in nature as determined by the Company (for example but not limitation, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

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

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

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

7. Elective procedures (for example but not limitation, the prophylactic extraction of third molars).

8. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).

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

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

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

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

9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the Schedule of Benefits or a Rider.
10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

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

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

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

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

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

12. For treatment of malignancies or neoplasms.
13. Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
15. Preventive restorations.
16. Periodontal splinting of teeth by any method.
17. For duplicate dentures, prosthetic devices or any other duplicative device.
18. For which in the absence of insurance the Member would incur no charge.
19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
20. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

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

21. For treatment and appliances for bruxism (night grinding of teeth).
22. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.

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

23. Incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).
24. Procedures that are:
 - part of a service but are reported as separate services; or
 - reported in a treatment sequence that is not appropriate; or
 - misreported or that represent a procedure other than the one reported.

25. Specialized procedures and techniques (for example but not limitation, precision attachments, copings and intentional root canal treatment).
26. Fees for broken appointments.
27. Those specifically listed on the Schedule of Benefits as "Not Covered" or "Plan Pays 0%".

28. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.
29. Orthodontic services, supplies, and appliances.

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

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

- Periapical – four (4) per 12 months per dentist if not performed in conjunction with definitive procedure(s).
- Occlusal – two (2) per 24 months under age eight (8).

18. General anesthesia and IV sedation: a total of sixty 60 minutes per session.

United Concordia Insurance Company

Dental 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 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

UNITED CONCORDIA INSURANCE COMPANY



Officer's Signature