UNITED CONCORDIA® DENTAL

Lehigh Valley Student Dental Plan Benefit Summary

Effective Date: 09/01/2017 **Network: Advantage *Plus***

Benefit Category[1]	CONCORDIA FLEX PLAN	
	In-Network[2]	Non-Network[2]
Class I – Diagnostic/Preventive Services		
Exams Bitewing X-rays All Other X-rays Cleanings & Fluoride Treatments Sealants Palliative Treatment Space Maintainers	100%	100%
Class II – Basic Services		
Basic Restorative (Fillings) Simple Extractions Repairs of Crowns, Inlays, Onlays, Bridges & Dentures Endodontics Nonsurgical Periodontics Surgical Periodontics Complex Oral Surgery General Anesthesia	80%	80%
Class III – Major Services		
Inlays, Onlays, Crowns Prosthetics (Bridges, Dentures)	0%	0%
Orthodontics for dependent children to age 19		
Diagnostic, Active, Retention Treatment	Not Applicable	Not Applicable
Included Plan Features		
Smile for Health®--Wellness[3] *Provides periodontal care for people with certain chronic medical conditions: diabetes, heart disease, lupus, oral cancer, organ transplant, rheumatoid arthritis and stroke*	• Covers 1 additional periodontal maintenance per year and all are covered at 100% • Scaling and root planing are covered at 100% • 4 periodontal surgery procedures are covered at 100%	
Maximums & Deductibles (applies to the combination of services received from network and non-network dentists)		
Annual Program Deductible (per person/per family)	$50/$150 Excludes Class I	
Annual Program Maximum (per person)	$1,000	
Lifetime Orthodontic Maximum (per person)	Not Applicable	
Reimbursement	**Advantage *Plus***	**Advantage MAC**

Representative listing of covered services – certificate of coverage provides a detailed description of benefits.

1. Reimbursement is based on our schedule of maximum allowable charges (MACs). Network dentists agree to accept our allowances as payment in full for covered services. Non-network dentists may bill the member for any difference between our allowance and their fee (also known as balance billing). United Concordia Dental's standard exclusions and limitations apply.
2. Reimbursement is based on our schedule of maximum allowable charges (MACs). Non-network dentists may bill the member for any difference between our allowance and their fee.

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. {For prosthetic services (e.g. full or partial dentures or fixed bridges) if such services replace one (1) or more teeth missing prior to Member's eligibility under the Group Policy.

    For Group Policies issued and delivered in Georgia and North Carolina, this exclusion does not apply.

    For Group Policies issued and delivered in Maryland, this exclusion does not apply to prosthetic services placed five (5) years after the Member's Effective Date for services.}{

30. Fluoride treatment; Space maintainers; Sealants; Prefabricated stainless steel crowns; Periodontal services; Basic restorations; Crowns, inlays, onlays; Buildups and post and cores; Fixed partial dentures, full dentures or partial removable dentures; Denture relining, rebasing or adjustments; Pulpal therapy; Root canal; Periapical and occlusal intraoral films; General anesthesia and IV sedation}

31. {Orthodontic services, supplies, and appliances.}}

LIMITATIONS – Covered services are limited as detailed below.

1. Full mouth x-rays – {one (1)} every {{60} months} {{5} {calendar or contract year(s)}}.
2. Bitewing x-rays – {one (1)} set(s) per {{6} months} {{1} {calendar or contract year(s)}} under age {fourteen (14)} and {one (1)} set(s) per {{12} months} {{1} {calendar or contract year(s)}} age {fourteen (14)} and older.
3. Oral Evaluations:
    - Comprehensive and periodic – {two (2)} of these services per {{12} months} {{1} {calendar or contract year(s)}}. 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} {{1} {calendar or contract year(s)}}.
    - Detailed problem focused – {one (1)} per dentist per patient per {{12} months} {{1} {calendar or contract year(s)}} per eligible diagnosis.
4. Prophylaxis – {two (2)} per {{12} months} {{1} {calendar or contract year(s)}}. {{One (1)} additional for Members under the care of a medical professional during pregnancy.}{
5. Fluoride treatment – {two (2)} per {{12} months} {{1} {calendar or contract year(s)}} 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 {teeth} {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 {{36} months} {{3} {calendar or contract year(s)}} {under age {sixteen (16)} on permanent first and second molars} {under age {eleven (11)} on permanent first molars and under age {sixteen (16)} on permanent second molars.}
8. Prefabricated stainless steel crowns – {one (1)} per tooth per lifetime for Members under age {fifteen (15)}.
9. Periodontal Services:
    - Full mouth debridement – {one (1)} per {{12} months} {{1} {calendar or contract year(s)}} {lifetime}.
    - Periodontal maintenance following active periodontal therapy – {two (2)} per {{12} months} {{1} {calendar or contract year(s)}} in addition to routine prophylaxis.
    - Periodontal scaling and root planing – {one (1)} per {{24} months} {{2} {calendar or contract year(s)}} per area of the mouth.
    - Surgical periodontal procedures – {one (1)} per {{24} months} {{2} {calendar or contract year(s)}} 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} {{2} {calendar or contract year(s)}} of previous placement of any basic restoration.
    - Single crowns, inlays, onlays – not within {{60} months} {{5} {calendar or contract year(s)}} of previous placement of any of the procedures in this category.
    - Buildups and post and cores – not within {{60} months} {{5} {calendar or contract year(s)}} of previous placement of any of the procedures in this category.
    - Replacement of natural tooth/teeth in an arch – not within {{60} months} {{5} {calendar or contract 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} {{1} {calendar or contract year(s)}} of insertion by the same dentist. Subsequent denture relining or rebasing limited to {one (1)} every {{36} months} {{3} {calendar or contract year(s)}} thereafter.

12. Pulpal therapy – {one (1)} per primary 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} {{1} {calendar or contract year(s)}}. Recementation during the first {{12} months} {{1} {calendar or contract year(s)}} following insertion any preventive, restorative or prosthodontic service by the same dentist is included in the preventive, restorative or prosthodontic service benefit.

15. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.

16. Payment for orthodontic services, if covered, 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} {{1} {calendar or contract year(s)}} {per dentist if not performed in conjunction with definitive procedure(s)}.}
    - {Occlusal – {two (2)} per {{12} months} {{1} {calendar or contract year(s)} {under age {eight (8)}}.}

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