2020

Effective Plan Year

UPMC Health Benefits Inc.
U.S. Steel Tower
600 Grant Street
Pittsburgh, PA15219

Pediatric Dental*
Certificate of Insurance

*The dental coverage described in this document is deemed an Essential Health Benefit (EHB) for Members Up to theage of 19 and applies only to those Members who meet this criteria.

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

UPMC Dental *Advantage*

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Class II: Basic Services

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

Class III: Major Services

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

Orthodontics (if medically necessary and approved by UPMC Dental *Advantage*)

Some plans may require orthodontics to be deemed Medically Necessary and approved by UPMC Dental *Advantage*. Refer to your employer-specific Schedule of Benefits for plan details. Orthodontics are subject to approval by UPMC Dental *Advantage*. Patients and only Medically Necessary when the patient attains or exceeds a score of 25 or higher on the Salzmann scale to be eligible for treatment. Orthodontics deemed Medically Necessary are treatment of poor alignment and occlusion. Coverage is for eligible dependents up to the age of 19.

- Orthodontics is also subject to the medical plan deductible
- Orthodontic treatment performed by a nonparticipating provider is not covered by the Plan.

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

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

Anesthesia

Anesthesia is not payable under UPMC Dental *Advantage*. However, the Member may have coverage for anesthesia services under his or her medical benefits.

General anesthesia and associated medical costs are provided to an eligible dental patient, which includes children 7 years of age or younger or developmentally disabled Members of any age for whom a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected for treatment under general anesthesia. Anesthesia coverage under the Member's medical plan may have limitations, restrictions, and requirements. Please refer to your medical Certificate of Coverage or plan documents.

Pediatric Dental Schedule of Benefits

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

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

Your out-of-pocket costs

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

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

Schedule of Exclusions

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

Claims

Claims submissions

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

To obtain a claim form, go to www.upmchealthplan.com. Be sure to include the following on the claim form:

- Member's name
- Member's date of birth
- Policyholder's Social Security number
- Policyholder's name and address
- The name and policy number of a second insurer if the Member is covered by another dental plan
- Proof of payment (if no proof of payment, the Member will need to include detailed information regarding the service – provider name, address, date of service, and amount charged)

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

Claim forms should be sent to:

UPMC Dental *Advantage*
PO Box 1600
Pittsburgh, PA 15230-1600

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

Notice of claim

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

Claim forms

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

Proof of Loss

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

Timely payment of claims

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

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

Payment of claims

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

Payment of benefits

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

If you receive treatment from a Nonparticipating Dentist, we will send payment for Covered Benefits to you unless otherwise indicated on the claim form. You will be notified of the Plan payment and any amounts you owe for Coinsurance, Deductibles, charges exceeding limits, or denial of noncovered services. The Plan payment will be based on the maximum allowable charge for the services. You will be responsible to pay the dentist any difference between the Plan's payment and the dentist's full charge for the service.

Change of Beneficiary

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

Overpayments

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

Coordination of benefits

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

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by that coverage will be taken into account when we determine if additional benefit payments can be made under this Plan.
- When you are covered as an employee under one plan and as a dependent under another, the employee coverage pays first.
- When the dependent child is covered under two plans, the plan covering the parent whose birthday occurs earlier in the calendar year pays first. If both parents have the same birthday, then the plan under which one parent was covered longest pays first.
- If the dependent child's parents are separated or divorced and:
  - The parent with custody of the child has not remarried, the coverage of the parent with custody pays first.
  - The parent with custody has remarried, the coverage of the parent with custody pays first, but the stepparent's coverage, if any, pays before the coverage of the parent without custody.
  - There is a court order that specifies the parent who is financially responsible for the child's dental expenses, the coverage of that parent pays first.
- When none of the above circumstances applies, the coverage that you have had the longest applies first, as long as:
  - The benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person, and the other plan does not have a provision regarding laid-off or retired employees and, therefore, the benefits of each plan are determined after the other, then the provisions listed above shall not apply.

If you or your provider receive more than you should have when your benefits are coordinated, you or your provider will be expected to repay the overpayment.

It is the policy of UPMC Dental *Advantage* to review all other insurance coverage prior to releasing a claim for payment. If other insurance coverage is found after a payment has been made, a review will determine which plan pays first and what action will be taken in regards to any claims in question. Whenever payments should have been made by the Plan, but payments were made under another benefit plan, UPMC Dental *Advantage* has the right to pay to the benefit plan that has made such payment any amount that the Plan determines to be appropriate under the terms of this Certificate. Any amounts paid shall be considered to be benefits paid in full under this Certificate.

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

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

Review of a benefit determination

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

Resolving Disputes with the Plan

At times, you may not be satisfied with a decision that the Plan makes regarding your coverage or with the dental services you have received. As a Member of UPMC Dental *Advantage*, you have the right to file a Complaint.

The Complaint process

A Member with a Complaint about a Participating Dentist, coverage, operations, or the Plan's management policies should contact our Health Care Concierge team at **1-877-648-9640.** TTY users should call **711.**

The Member may appoint in writing a representative to act on his or her behalf. In addition, the Member or the Member's representative may request the help of a Plan employee who has not taken part in the decision to deny coverage or the issue in dispute. That employee will assist the Member in preparing the Complaint at no charge to the Member. Complaints must be filed with UPMC Dental *Advantage* within 180 days from denial notification or from the occurrence.

There is one step in the internal Complaint process — the initial review, which is described in this section.

Initial review

1. **Member files a Complaint**.

   Complaints may be verbal or in writing and may include documentation. The Complaint should indicate the remedy or corrective action being sought. For example, a Complaint may deal with a claim denial, and the remedy being sought is payment of the claim. All written Complaints should be submitted to:

   UPMC Dental *Advantage*
   Member Complaints
   PO Box 2939
   Pittsburgh,
   PA 15230-2939

   Verbal Complaints can be made to our Health Care Concierge team by calling **1-877-648-9640.** TTY users should call **711.**

2. **UPMC Dental *Advantage* acknowledges the Complaint.**

   The Plan sends a letter to the Member within five business days stating that it has received the Complaint.

3. **The Initial Complaint Review Committee investigates the Complaint.**

   The committee, which consists of one or more Plan employees, investigates the Complaint.

4. **The committee makes a decision and notifies the Member.**

   The committee makes a decision within 30 calendar days of receiving a Complaint. The committee notifies the Member in writing within five business days of making its decision, giving its reasons and the Member's appeal rights, if applicable.

If the Member accepts the decision of the Initial Complaint Review Committee, no further action is required. However, if the Member wishes to appeal this decision AND the Member's employer provides health benefits to him or her through a group health plan, the Member may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). The Member should contact his or her employer to obtain additional information concerning his or her rights under ERISA.

Schedule of Exclusions

What is not covered?

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

- **Blood**: Nonpurchased blood or blood products, including autologous donations.
- **Cosmetic surgery**: Surgical or other services performed solely for cosmetic reasons — to repair or reshape a body structure for the improvement of the person's appearance or for psychological or emotional reasons and from which no improvement in physiological function can be expected, such as mouth guards and adult fluorides.
- **Court-ordered services**: Court-ordered services when your dentist or other professional provider determines that those services are not dentally appropriate.
- **Employment-related or employer-sponsored services**:
  - A. For any illness or bodily injury that occurs in the course of employment, if benefits or compensation is available in whole or in part, pursuant to any federal, state, or local government's workers' compensation, or occupational disease, or similar type of legislation. This exclusion applies whether or not you claim those benefits or compensation.
  - B. Services that you receive from a dental or medical department, operated in whole or in part by, or on behalf of, an employer, mutual benefit association, labor union, trust, or similar entity.
- **Experimental/Investigational**: Services that are Experimental/Investigational in nature as determined by the Plan.
- **Medical/Dental services not identified as "covered" in this Certificate**: Any other medical or dental service or treatment, except as provided in this Certificate or as mandated by law.
- **Medicare**: Services for which or to the extent that payment has been made pursuant to Medicare coverage, when Medicare coverage is primary; however, this exclusion does not apply when your employer or group plan sponsor is required to offer you all of the benefits set forth in this Certificate by law, and you elect this coverage as your primary coverage.
- **Military service**:
  - A. Care for military service-connected disabilities and conditions for which you are legally entitled to services and for which facilities are reasonably accessible to you.
  - B. Services that are provided to Members of the armed forces and the National Health Service or to individuals in Veterans Affairs facilities for military service-related illness or injury, unless you have a legal obligation to pay.
- **Miscellaneous**: Any services, supplies, or treatments not specifically listed in the Certificate as covered benefits, services, supplies, or treatments, unless they are a basic dental service. A. Any services related to or necessitated by an excluded item or noncovered service.
  - B. Services provided by a nonlicensed practitioner.
  - C. Services that are primarily educational in nature, including, but not limited to, instruction for plaque control, oral hygiene, and diet.
  - D. Services incurred after the date of termination of your coverage, except as provided elsewhere in this Certificate. Services rendered prior to the effective date of your coverage.

E. Services for which you otherwise would have no legal obligation to pay.

F. Charges for telephone consultations unless otherwise allowed in accordance with Plan policy.

G. Charges for failure to keep a scheduled appointment.

H. Services performed by a dentist enrolled in an education or training program when such services are related to the education or training program.

I. Charges for completion of any insurance form or copying of dental or medical records.

J. Services that are submitted by two different dentists for the same services performed on the same date for the same individual.

K. Services for, or related to, any illness or injury suffered after the effective date of your coverage that is the result of any act of war.

L. Services that are more than the maximum allowable charge.

M. Charges for care that is not dentally necessary.

N. Expenses incurred by you to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. The Plan will take into account any adjustment option chosen under such part by you.

O. Replacement of a lost or stolen appliance.

P. Replacement of a bridge, crown, or denture within 60 months after the date it was originally installed.

Q. Procedures, appliances, or restorations (except full dentures) whose main purpose is to (a) change vertical dimension, (b) diagnose or treat conditions or dysfunction of the temporomandibular joint, (c) stabilize periodontally involved teeth, or (d) restore occlusion to include orthodontics for Members age 19 and over.

R. Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second, or third molars.

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

General Provisions

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

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

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

The pertinent laws and regulations for interpretation and enforcement of the Certificate are the laws and regulations of the Commonwealth of Pennsylvania.

Entire contract; changes

Subject to the contract between your employer and The Plan, this Certificate of Insurance, including the schedules, riders, and other documents attached hereto and issued in accordance herewith, represents the entire contract of insurance between you and the Plan. No agent or representative of the Plan other than a Health Plan officer may otherwise change this Certificate of Insurance or waive any of its provisions. All statements you made will, in the absence of fraud, be deemed representations, and not warranties, and no such statement will be in defense to a claim under this Certificate of Insurance, unless it is contained in a written instrument signed by and furnished to you.

Physical examinations

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

Legal actions

No action in law or in equity shall be brought to recover on the Certificate prior to the expiration of 60 days after written Proof of Loss has been filed in accordance with the requirements of the Certificate. No such action shall be brought after the expiration of three years after the time written Proof of Loss is required to be furnished.

Time Limit on Certain Defenses

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

Misstatement of age

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

Reinstatement

If your coverage under this Certificate has been terminated for failure to pay premiums, the Plan will reinstate your coverage as long as the premium due is paid in full within 30-calendar days after the end of the grace period. The reinstated Certificate shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

Fraud and abuse

According to Pennsylvania statute:

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

The Plan is committed to ensure the integrity of, provision of, and payment for Dentally Necessary Covered Services to our Members. In the event that you suspect that a UPMC Dental *Advantage* Member or a provider is committing fraud or abuse, contact our Special Investigations Unit at 1-866-FRAUD01 (1-866-372-8301) or specialinvestigationsunit@upmc.edu.

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2019 DNTL SG PED COi 18CG-IND146973-04 (MCG) 4/30/18 PDF