United Concordia Dental Plans of Pennsylvania, Inc.

4401 Deer Path Road
Harrisburg, PA 17110
877-215-3616
www.unitedconcordia.com

Dental Plan
Certificate of Coverage

University of Pittsburgh
Graduate Students

253212001, 253212011, 253212021, 253212071, 253212171

September 1, 2017 through August 31, 2018

The benefit Plan made available under this Certificate utilizes a preferred provider arrangement.

Services under this Plan must be provided by a Concordia Plus In-Network Dentist as stated under the terms of this Certificate in the Covered Services Section.

United Concordia Dental Plans of Pennsylvania, Inc. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Coverage of medically necessary health services is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. United Concordia Dental Plans of Pennsylvania, Inc. will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. United Concordia Dental Plans of Pennsylvania, Inc. will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

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Discrimination is Against the Law
The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmark.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-332-0366 (TTY: 711).
Español (Spanish)	ATENCIÓN: Si habla español, le ofrecemos servicios gratuitos de asistencia lingüística. Llame al 1-800-332-0366 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-0366 (TTY: 711)。
Tiếng Việt (Vietnamese)	CHÚ Ý: Nế u quý vị nói Tiế ng Việ t, chúng tôi có các dị ch vụ hỗ trợ ngôn ngữ miễ n phí dành cho quý vị . Gọ i số 1-800-332-0366 (TTY: 711).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-0366 (TTY: 711) 번으로 전화해 주십시오.
Tagalog (Tagalog - Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-332-0366 (TTY: 711).
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните 1-800-332-0366 (телетайп: 711).
العربية (Arabic)	يرجى الانتباه: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة للغوية المجانية. اتصل على 1-800-332-0366 (TTY: 711)
Kreyòl Ayisyen (French Creole)	ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis èd nan lang ki disponib gratis pou ou. Rele nimewo 1-800-332-0366 (TTY: 711).
Français (French)	ATTENTION : si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Appelez le 1-800-332-0366 (ATS: 711).
Polski (Polish)	UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-0366 (TTY: 711).
Português (Portuguese)	ATENÇÃO: se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-800-332-0366 (TTY: 711).
Italiano (Italian)	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-332-0366 (TTY: 711).
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Dienste für die sprachliche Unterstützung zur Verfügung. Rufnummer: 1-800-332-0366 (TTY: 711).
日本語 (Japanese)	注意事項：日本語をお使いの方は、言語面でのサポートを無償でご利用いただけます。1-800-332-0366（TTY: 711）まで、お電話にてご連絡ください。
فارسی (Farsi)	توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-332-0366 (TTY: 711) تماس بگیرید.

CERTIFICATE OF COVERAGE

INTRODUCTION

This Certificate of Coverage 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 Contract with United Concordia. The benefits are available to You as long as the Premium is paid and obligations under the Group Contract are satisfied. In the event of conflict between this Certificate and the Group Contract, the Group Contract 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:

877-215-3616

For general information, In-Network 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 69422
Harrisburg, PA 17106-9422

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TABLE OF CONTENTS

Attached:

Appeal Procedure Addendum
State Law Provisions Addendum, If Applicable
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 – The Health Insurance Marketplace authorized by law or regulation in Pennsylvania 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 Contractholder, 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 Contract that covers only dependent children, the Certificate Holder must be the child's or children's parent, stepparent, legal guardian, or legal custodian. Also referred to as "You" or "Your" or "Yourself."

Certificate of Coverage ("Certificate") - This document, including riders, schedules, addenda and/or endorsements, if any, which describes the coverage purchased from the Company by the Contractholder.

Company - The United Concordia Dental Plan indicated on the cover page of this Certificate.

Contractholder - Organization that executes the Group Contract. Also referred to as "Your Group".

Contract Year - The period of twelve (12) months beginning on the Group Contract's Effective Date or the anniversary of the Group Contract'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.

Copayments - Those amounts set forth in the Schedule of Benefits that the Certificate Holder or his/her enrolled Dependents are responsible to pay the treating dentist.

Cosmetic - Those procedures which are undertaken primarily to improve or otherwise modify the Member's appearance when the cause is not related to accidental injury.

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 In-Network Dentists in accordance with the terms of this Certificate.

Dental Emergency - An acute condition occurring suddenly and unexpectedly, which usually includes pain, swelling or bleeding, and demands immediate professional dental services.

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. The Member shall be held harmless if, after receiving services from a Primary Dentist or Specialty Care Dentist, such services are determined not Dentally Necessary.

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

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

1. The Certificate Holder's spouse, or domestic life partner as defined by the Contractholder and/or state law; and
2. Any unmarried natural child, stepchild, adopted child or child placed with the Certificate Holder or the Certificate Holder's Spouse, or domestic partner by order of a court or administrative agency:
   (a) until the end of the month that the child reaches age nineteen (19); or
   (b) until the end of the month which he/she reaches the limiting age of twenty-six (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;
   (c) when an enrolled full-time student's education is interrupted by military service, until the end of the period beyond the above-stated student age limit, equal to the duration of the enrolled full-time student's service of thirty (30) or more consecutive days on active duty for any reserve component of the United States armed forces or the Pennsylvania National Guard, including State duty or until said enrollee is no longer a full-time student, whichever is sooner; or
   (d) 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.

For a child under the limiting age listed above, the following factors will not affect eligibility to enroll as a Dependent: financial dependency on or residency with the Certificate Holder; marital status; student status; employment; eligibility to enroll for coverage under another policy or contract, or any combination of these factors.

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

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

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

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

Grace Period - A period of no less than thirty-one (31) days after Premium payment is due under the Group Contract, in which the Contractholder may make such payment and during which the protection of the Group Contract continues, subject to payment of Premium by the end of the Grace Period.

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

In-Network Dentist - A Primary Dental Office or a Specialty Care Dentist.

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 Contract, 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 incorporated by reference into this Certificate.

Member(s) - Certificate Holder(s) and their Dependent(s).

Out-of-Network Dentist - A general or specialty care dentist who has not signed a contract with Us. Also referred to as "Non-Participating Provider."

Out-of-Pocket Expense(s) - Cost not paid by Us, including but not limited to Copayments, amounts billed by Out-of-Network Dentists except as specified in the Dental Emergencies and Out-of-Network Care provision of this Certificate, costs of services that exceed the Group Contract's Limitations, Annual Maximum or Lifetime Maximums, or for services that are Exclusions. The Certificate Holder is responsible for Out-of-Pocket Expenses.

Out-of-Pocket Maximum - The limit on Copayments and Deductibles from Primary Dentists and Specialty Care Dentists that the Certificate Holder is required to pay in a Contract Year, as shown on the Schedule of Benefits. After this limit is reached, Covered Services from Primary Dental Providers and Specialty Care Dentists is paid 100% by the Plan for the remainder of the Contract Year, 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.

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

Primary Dental Office - Approved office of a Primary Dentist who has executed a contract with Us to offer Covered Services to Members.

Primary Dentist - A general Dentist whose office has executed a contract with Us, under which he/she agrees to provide Covered Services to Members for a monthly fee plus any applicable supplements and Copayments, as payment in full for services rendered.

Renewal Date - The date on which the Group Contract renews. Also known as "Anniversary Date."

Schedule of Benefits - Attached summary of Covered Services and Copayment, 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 individuals eligible as Certificate Holders or Dependents who experience certain qualifying events may enroll in this Group Contract.

Specialty Care Dentist - A specialized Dentist who is board eligible, board qualified, or board certified in one of the specialty areas of periodontics, oral surgery, orthodontics, endodontics and pediatrics and who has executed a contract with Us to accept negotiated fees plus any applicable Copayments, as payment in full for Covered Services provided to Members.

Spouse - The Certificate Holder's partner by marriage or by any union between two adults that is recognized by law in Pennsylvania.

State Law Provisions Addendum – Attached document, if any, containing specific provisions required by state law to be modified, deleted from, and/or added to the Certificate of Coverage.

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

Waiting Period(s) - A period of time a Member must be enrolled under the Group Contract before certain benefits will be paid for 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 Group Contract.

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

In order to be a Member, You must meet the eligibility requirements of Your Group, this Group Contract. If You are enrolling through an Authorized Entity, You must meet any additional eligibility requirements of such entity and provide enrollment information to it. We must receive enrollment information for the Certificate Holder, enrolled Dependents, and Contractholder. 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 Contract Effective Date and Your enrollment information and applicable Premium is supplied to Us, Your coverage will begin on the Group Contract Effective Date.

If You are not eligible to be a Member on the Group Contract 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 Contract Effective Date will begin on the first day of the month following 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 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;
- change in domestic partnership status.

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 thirty-one (31) days of the date of the life change event. The Dependent must meet the definition of Dependent applicable to this Group Contract.

The Certificate Holder may also add or remove Dependents or change Plans for the reasons defined by and during the timeframes specified by applicable law or regulation.

When an enrolled, full-time student's education is interrupted by military service as detailed in the Definition of Dependent of this Certificate, enrollment may be extended beyond the limiting age for full-time students. To qualify for the extension, the Member must submit the required Department of Military

and Veterans Affairs (DMVA) forms to notify Us of placement on active duty, of completion of active duty and of re-enrollment as a full-time student for the first term or semester starting sixty (60) or more days after release from active duty. The DMVA forms are available online at *www.dmva.state.pa.us*.

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 Contract.

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 newborns or within sixty (60) days from placement for adopted children.

If You have an enrolled Dependent child who is a full-time student at an accredited educational institution, proof of his/her student status and reliance on You for maintenance and support must be furnished to Us within thirty (30) days after he/she attains the limiting age shown in the definition of Dependent. This proof of student status will be requested annually thereafter until the Dependent reaches the limiting age for students and his/her coverage ends.

If You have an enrolled Dependent child who is mentally or physically handicapped, proof 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 he/she attains the limiting age shown in the definition of Dependent. Such evidence will be requested 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.

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. 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

Entire Contract

This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses

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

No claim for loss incurred or disability (as defined in the Policy) commencing after three years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

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, located at 4401 Deer Path Road, Harrisburg, PA 17110, 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 fifteen (15) 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-Participating 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 (to be paid not less than monthly) contingent upon continuing loss within ninety (90) days after the termination of the period for which the Company is liable and in case of claim for any other loss within ninety (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 one (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 thirty (30) days from receipt of due written proof of such loss. The Company may extend this thirty-day period by no more than fifteen (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.

Payment of Claims

All benefits under this policy shall be payable to the Participating Dentist or the Member, or to his designated beneficiary or beneficiaries, or to his estate, except that if the Member be a minor or otherwise not competent to give a valid release, such benefits may be made payable to his custodial parent, guardian, or other person actually supporting him. All or a portion of any indemnities provided by this Policy on account of dental services may, at the option of the Company and unless the Member requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the dental office rendering such services.

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.

Legal Actions

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty (60) days after written proof of loss has been filed in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Change of Beneficiary

Unless the Member makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Member and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Policy or to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

Choice of Provider at Enrollment

You must select a Primary Dental Office for Yourself and Your Dependents. Each Member may select a different Primary Dental Office. If You or Your Dependents do not select a Primary Dental Office, You will be assigned to one in a location convenient to Your home zip code. The Primary Dental Offices will be notified of Your selection or assignment.

To find a Primary Dental Office, visit Our website or call the toll-free number in the Introduction section of this Certificate or on Your ID card.

Once enrolled, You will receive an ID Card or other notification indicating Your contract ID number, plan number and Group number and the names of the Primary Dental offices You and Your Dependents selected or that were assigned by Us. Present Your ID card to Your dental office or give the office Your ID number, Plan number and Group number. If Your Dentist has questions about Your eligibility or benefits, instruct the office to call Us or visit Our website.

Changing Primary Dental Offices

You or Your Dependents may request to change Primary Dental Offices at any time. Simply call our Customer Service center toll-free at the number in the Introduction section of this Certificate or visit Our

website. You will be informed of the effective date of Your transfer, and the newly selected office will also be notified. You must request the transfer prior to seeking services from the new Primary Dental Office. Any dental procedures in progress must be completed before the transfer.

If You or Your Dependents are enrolled in a Primary Dental Office that stops participating in the Plan, We will notify You and assist You or Your Dependents with selecting another Primary Dental Office.

Coordination of Care and Referrals

The Primary Dental Office assigned to You or Your Dependents must provide or coordinate all Covered Services. When specialty care such as surgical treatment of the gums or a root canal is needed, the Primary Dentist may perform the procedure or give You a written referral to a Specialty Care Dentist. With the exception of Dental Emergencies or if a Primary Dentist or Specialty Care Dentist is not available in Your area, all benefits must be provided by an In-Network Dentist. See the next section entitled Dental Emergencies and Out-of-Network Care for details on these situations.

When specialty care such as surgical treatment of the gums or a root canal is needed, the Primary Dentist may perform the procedure or refer You to a specialist. All referrals must be made to a participating Specialty Care Dentist. Your Primary Dentist will give You a written referral to take to the Specialty Care Dentist. The Specialty Care Dentist will perform the treatment and submit a claim and the referral to Us for processing. The claim will be denied if the written referral is not submitted. Referral is limited to endodontic, orthodontic, periodontic, oral surgery, and pedodontic Specialty Care Dentists.

Should You have any questions concerning Your coverage, eligibility or a specific claim, contact Us at the address and telephone number in the Introduction section of this Certificate or log onto Our website.

There are only two (2) situations when You may receive a benefit for Covered Services performed by an Out-of-Network Dentist: Dental Emergencies; and when an In-Network Dentist is not available in Your area.

Dental Emergencies

If You have a Dental Emergency, You should contact Your Primary Dental Office or go to a conveniently located general Dentist. Ask the dental office to call Our Customer Service Unit to verify coverage. Obtain an itemized bill from the dental office to submit to Us. The Plan will cover certain diagnostic and therapeutic procedures in accordance with the Schedule of Benefits and the Schedule of Exclusions and Limitations. Your cost will be limited to any applicable Copayment on the Schedule of Benefits. You must return to Your Primary Dental Office for any necessary follow-up care.

Out-of-Network Care

In the event that a Specialty Care Dentist is not available within a thirty (30) mile radius of Your home, We may arrange treatment by an Out-of-Network Dentist. Call Our Customer Service unit at the telephone number listed in the Introduction section of this Certificate. The unit will arrange a visit to an Out-of-Network Dentist. Your cost will be limited to the Copayment listed on the Schedule of Benefits as long as the dental procedure is covered under the Plan.

BENEFITS

Covered Services

Benefits and any applicable Copayments, Deductibles, Annual Maximums, Lifetime Maximums, Out-of-Pocket Maximums and Waiting Periods are shown on the attached Schedule of Benefits. Services shown on the Schedule of Benefits as covered are subject to frequency or age Limitations detailed on the attached Schedule of Exclusions and Limitations.

Only services, supplies and procedures listed on the Schedule of Benefits are Covered Services. For items not listed (not covered), You are responsible for the full fee charged by the Dentist. No benefits will be paid for services, supplies or procedures detailed under the Exclusions on the Schedule of Exclusions and Limitations.

Exclusions

No benefits will be provided for services, supplies or charges detailed as Exclusions on the Schedule of Exclusions and Limitations. Services shown on the Schedule of Benefits as covered may also be subject to frequency or age Limitations as detailed on the attached Schedule of Exclusions and Limitations.

Copayments and Other Charges

Copayments
In order to keep the Plan affordable for You and Your Group, the Plan includes certain cost-sharing features. First, not all dental procedures are covered. If the procedure is not listed on the Schedule of Benefits, it is not covered. You will be responsible to pay Your Dentist the full charge for the uncovered service.

Certain procedures listed on the Schedule of Benefits require You to pay a Copayment. Copayments are listed in the right-hand column on the Schedule. You are responsible to pay the Copayments at the time of service unless You have made other arrangements with the Primary Dental Office or Specialty Care Dentist. Copayments are the same whether the service is provided by Your Primary Dentist or by a Specialty Care Dentist through referral. Services listed on the Schedule of Benefits with a “0” or “N/C” in the column require no Copayment from You.

Services listed on the Schedule of Benefits are also subject to Exclusions and Limitations. Be sure to review both the Schedule of Benefits and the Schedule of Exclusions and Limitations attached to this Certificate. Services not listed on the Schedule of Benefits, Exclusions, or those beyond stated Limitations are not covered and are Your responsibility.

Other Charges for Alternative Treatment
All diagnosis and treatment planning is provided by Your Primary Dental Office. Frequently, several alternate methods exist to treat a dental condition. For example, a tooth can be restored with a crown or a filling, and missing teeth can be replaced either with a fixed bridge or a partial denture. We will make payment based upon the allowance for the less expensive procedure, provided that the less expensive procedure meets accepted standards of dental treatment. Our decision does not commit You to the less expensive procedure. However, if You and the Dentist choose the more expensive procedure, You are responsible for the additional charges beyond those paid or allowed by the Company.

Occasionally, You and Your Primary Dental Office may consider alternative treatment plans that are not Covered Services. In those instances, You are responsible for the additional cost for the alternative treatment. The cost of the alternative treatment will be calculated on the difference between the provider’s usual fee for the alternative treatment and the usual fee for the Covered Service plus the Copayment of the Covered Service.

Payment of Benefits

We will pay covered benefits directly to Your assigned Primary Dental Office or the Specialty Care Dentist. Payment is based on allowances contracted with In-Network Dentists. All contracts between Us and the In-Network Dentists state that under no circumstances will the Member be liable to any Dentist for any sum owed by Us to the Dentist. In any instance where We fail or refuse to pay the Dentist, such dispute is solely between the Dentist and Us. Other than Copayments, the Member is not liable for any monies We fail or refuse to pay.

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. The following words and phrases regarding the Coordination of Benefits ("COB") provision are defined as set forth 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 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 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 state and federal law. Each person claiming benefits under This Plan must give any facts needed to pay the claim.

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

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

Workers' Compensation

When a Member is eligible for Workers' Compensation benefits through employment, the cost of dental treatment for an injury which arises out of and in the course of Member's employment is not a covered benefit under this Plan. Therefore, if the Company pays benefits which are covered by a Workers' Compensation Contract, the Company has the right to obtain reimbursement for those benefits paid. The Member must provide any assistance necessary, including furnishing information and signing necessary documents, for the Company to receive the reimbursement.

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. If, after speaking with a Customer Service representative, You are still dissatisfied, refer to the Appeal Procedure Addendum attached to this Certificate for further steps You can take regarding Your claim.

TERMINATION -- WHEN COVERAGE ENDS

A Member's coverage will end at 12:00 AM:

- on the date You no longer meet Your Group's eligibility requirements; or

- on the date Premium payment ceases for You; or
- on the date Your Dependent(s) cease to meet the requirements in the definition of Dependent in the Definitions section of this Certificate;
- on the date You no longer meet other eligibility requirements imposed by an Authorized Entity; or
- on the termination date specified for You by an Authorized Entity; or
- on the postmark date of the notice We provide to You regarding a final disposition of a fraud conviction for the Certificate Holder or his/her Dependents; or
- on the date the Certificate Holder's residence changes to an area outside the State of Pennsylvania.

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 a State Law Provisions Addendum to this Certificate. If the Group Contract is cancelled, Certificate Holder and Dependent coverage will end on the Group Contract Termination Date.

Grace Period: The Company may terminate the Group Contract upon default in the payment of Premium by giving to the Contractholder thirty-one (31) days prior written notice of such termination or nonrenewal. Notice to the Contractholder shall state the amount of Premium due and the Grace Period for payment. Payment of said sum prior to the date of intended termination shall continue this Group Contract in full force and effect. If payment is not remitted by the end of the Grace Period, the Group Contract will terminate and coverage will end on the first day following the expiration of the Grace Period. During the Grace Period, coverage shall continue in effect regardless of non-payment of Premium.

Reinstatement: If any renewal Premium is not paid within the time granted the Group for payment, a subsequent acceptance of Premium by the Company or by any agent duly authorized by the Company to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy. However, if the Company requires an application for reinstatement and issues a conditional receipt for the Premium, the Policy will be reinstated upon approval of such application by the Company. Lacking such approval, the Policy will be reinstated upon the forty-fifth day following the date of such conditional receipt unless the Company has previously notified the Policyholder in writing of its disapproval of such application. The Policyholder and Company shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

We are not liable to pay any benefits for services that are started after the 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, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Termination Date.

CONTINUATION COVERAGE

Federal or state law may require that certain employers offer continuation coverage to Members for a specified 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 this requirement does apply, You must elect to continue coverage within sixty (60) days from Your qualifying event or 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

This Certificate includes and incorporates any and all riders, endorsements, addenda, and schedules and together with the Group Contract represents the entire agreement between the parties with respect to the dental Plan. 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 Pennsylvania.

Privacy and Confidentiality of Dental Records

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

A statement describing our policies and procedures for preserving the confidentiality of dental records is available and will be furnished to You upon request.

ADDENDUM TO CERTIFICATE

APPEAL PROCEDURE

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

If You are dissatisfied with Our benefit determination on a claim, You may appeal Our decision by following the steps outlined in this procedure. We will resolve Your appeal in a thorough, appropriate, and timely manner 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) 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 or not Dentally Necessary or appropriate.

"Authorized representative" is a person granted authority by You and the Company to act on Your behalf regarding a claim for benefit 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.

"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

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 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 upon request and free of charge, 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;
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."

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.