

# *Your Dental Benefits*

***ConcordiaFLEX***

**WILKES UNIVERSITY**

**HIGH OPTION**





## **UNITED CONCORDIA**

**4401 Deer Path Road  
Harrisburg, PA 17110**

### **Dental Plan Certificate of Insurance**

### **Network Plan**

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

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

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

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

# **CERTIFICATE OF INSURANCE**

## **INTRODUCTION**

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

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

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

(800) 332-0366

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Attached:

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

## DEFINITIONS

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

**Certificate Holder(s)** - An individual who has enrolled him/herself and his/her Dependents for dental coverage and for whom Premium payments are due and payable. Also referred to as "You" or "Your" or "Yourself".

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

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

**Company** - United Concordia, the insurer. Also referred to as "We", "Our" or "Us".

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

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

**Covered Service(s)** - A service or supply specified in this Certificate and the Schedule of Benefits for which benefits will be covered subject to the Schedule of Exclusions and Limitations, when rendered by a dentist, or any other duly licensed dental practitioner under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

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

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

**Dependent(s)** - Certificate Holder's spouse or domestic life partner as defined by the Policyholder and/or state law and any unmarried child or stepchild of a Certificate Holder or unmarried member of the Certificate Holder's household resulting from a court order or placement by an administrative agency, enrolled in the Plan:

- (a) until the end of the calendar year which he/she reaches age 19; or
- (b) until the end of the calendar year which he/she reaches age 23 if he/she is a full-time student at an accredited educational institution and chiefly reliant upon the Certificate Holder for maintenance and support; or
- (c) to any age if he/she is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

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

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

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

**Grace Period** - A period of no less than 31 days after Premium payment is due under the Policy, in which the Policyholder may make such payment and during which the pr



For an enrolled Dependent child who is a full-time student, evidence of his/her student status and reliance on You for maintenance and support must be furnished to Us within 30 days after said Dependent attains the limiting age shown in the definition of Dependent. Such evidence will be requested annually thereafter until the Dependent reaches the limiting age for students and his/her coverage ends.

For an enrolled Dependent child who is mentally or physically handicapped, evidence of his/her reliance on You for maintenance and support due to his/her condition must also be supplied to Us within 30 days after said Dependent attains the limiting age shown in the definition of Dependent. If the Dependent is a full-time student at an accredited educational institution, the evidence must be provided within 30 days after the Dependent a



- the patient's name
- date of birth
- Your contract ID number
- patient's relationship to You
- Your name and address
- the name and policy number of a second insurer if the patient is covered by another dental plan.

Your dentist should complete the treatment and provider information or supply an itemized receipt for You to attach to the claim form. Send the claim form or predetermination to the address in the Introduction section of this Certificate.

For orthodontic treatment, if covered under the Plan, an explanation of the planned treatment must be submitted to Us. Upon review of the information, We will notify You and Your dentist of the reimbursement schedule, frequency of payment over the course of the treatment, and Your share of the cost.

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 *My Dental Benefits* at [www.unitedconcordia.com](http://www.unitedconcordia.com).

### **Predetermination**

A predetermination is a review in advance of treatment by Us to determine patient eligibility and coverage for planned services. Predetermination is not required to receive a benefit for any service under the Plan. However, it is recommended for extensive, more costly treatment such as crowns and bridges. A predetermination gives You and Your dentist an estimate of Your coverage and how much Your share of the cost will be for the treatment being considered.

To have services predetermined, You or Your dentist should submit a claim showing the planned procedures but leaving out the dates of services. Be sure to sign the predetermination request. Substantiating material such as radiographs and periodontal charting may be requested by Us to estimate benefits and coverage. We will determine benefits payable, taking into account Exclusions and Limitations including alternate treatment options based upon the provisions of the Plan. We will notify you of the estimated benefits.

When the services are performed, simply have Your dentist call Our Interactive Voice Response System at the telephone number in the Introduction section of this Certificate, or fill in the dates of service for the completed procedures on the predetermination notification and re-submit it to Us for processing. Any predetermination amount estimated is subject to continued eligibility of the patient. We may also make adjustments at the time of final payment to correct any mathematical errors, apply coordination of benefits, and comply with Your Plan in effect and remaining program Maximum dollars on the date of service.

## **BENEFITS**

### **Schedule of Benefits**

Your benefits are shown on the attached Schedule of Benefits. The Schedule of Benefits shows:

- the classes and groupings of dental services covered, shown with a "Plan Pays" percentage greater than "0%".
- the percentage of the Maximum Allowable Charges the Plan will pay.
- any Waiting Periods that must be satisfied for particular services before the Plan will pay benefits. Waiting Periods are measured from date of enrollment in the Plan.

- any Deductibles You and/or Your family must pay before any benefits for Covered Services will be paid by the Plan, and the Covered Services for which there is no deductible. The Deductible is applied only to expenses for Covered Services and on either a calendar year or contract year basis (yearly period beginning with the Effective Date of the Group Policy).
- any Maximums for Covered Services for a given period of time; for example, annual for most services and lifetime for orthodontics. Annual Maximums are applied on either a calendar or contract year basis.

### **Your Out-of-Pocket Costs**

In order to keep the Plan affordable for You and Your Group, the Plan includes certain cost-sharing features. If the class or service grouping is not covered under the Plan, the Schedule of Benefits will indicate either “not covered” or “Plan Pays -- 0%”. You will be responsible to pay Your dentist the full charge for these uncovered services.

Classes or service groupings shown with “Plan Pays” percentages greater than 0% but less than 100% require you to pay a portion of the cost for the Covered Service. For example, if the Plan pays 80%, Your share or Coinsurance is 20% of the Maximum Allowable Charge. You are also responsible to pay any Deductibles, charges exceeding the Plan Maximums or charges for Covered Services performed before satisfaction of any applicable Waiting Periods.

### **Services**

The general descriptions below explain the services on the Schedule of Benefits. The descriptions are not all-inclusive – they include only the most common dental procedures in a class or service grouping. Specific dental procedures may be shifted among groupings or classes or may not be covered depending on Your Group’s choice of Plan. Check the Schedule of Benefits attached to this Certificate to see which groupings are covered (“Plan Pays percentage greater than “0%”). Also, have Your provider call Us to verify coverage of specific dental procedures or log on to *My D or Iof 0-ce0i2-ce0i2-ce0i2-ce0i2- n*

## **Exclusions and Limitations**

Services indicated as covered on the Schedule of Benefits are subject to frequency or age Limitations detailed on the attached Schedule of Exclusions and Limitations. The existence of a Limitation on the Schedule of Exclusions and Limitations does not mean the service is covered under the Plan. Before reviewing the Limitations, You must first check the Schedule of Benefits to see which services are covered. No benefits will be provided for services, supplies or charges detailed under the Exclusions on the Schedule of Exclusions and Limitations.

## **Payment of Benefits**

If You have treatment performed by a Participating Dentist,

- C) **Other Dental Plan** is any form of coverage which is separate from this Plan with which coordination is allowed. **Other Dental Plan** will be any of the following which provides dental benefits, or services, for the following: Group insurance or group type coverage, whether insured or uninsured. It also includes coverage other than school accident type coverage (including grammar, high school and college student coverages) for accidents only, including athletic injury, either on a twenty-four (24) hour basis or on a "to and from school basis," or group or group type hospital indemnity benefits of \$100 per day or less.
  - D) **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.
  - E) **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.
  - F) **Plan** means this document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.
2. The fair value of services provided by the Company will be considered to be the amount of benefits paid by the Company. The Company will be fully discharged from liability to the extent of such payment under this provision.
3. In order to determine which plan is primary, this Plan will use the following rules.
- A) If the other plan does not have a provision similar to this one, then that plan will be primary.
  - B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.
  - C) Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:
    - 1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
    - 2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
    - 3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
    - 4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
  - D) Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:
    - 1) First, the plan of the parent with custody of the child.
    - 2) Then, the plan of the spouse of the parent with the custody of the child; and
    - 3) Finally, the plan of the parent not having custody of the child.
    - 4) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
    - 5) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 3-C) above, titled Dependent Child/Parents Not Separated or Divorced.
  - E) Active/Inactive Member
    - 1) For actively employed Members and their spouses over the age of 65 who are covered by Medicare, the plan will be primary.
    - 2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.
  - F) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary.

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

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

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If Your coverage ends, Your Dependents' coverage will end on the same date unless otherwise specified in a State Law Provisions Addendum to this Certificate. If the Group Policy is cancelled, Your coverage and

## **ADDENDUM TO CERTIFICATE**

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### **Time Payment of Claims**

All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid no later than 30 days from receipt of due written proof of such loss. The Company may extend this 30-day period by no more than 15 days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Company. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid quarterly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

### **Payment of Claims**

All benefits under this policy shall be payable to the Participating Dentist or the Insured Person, 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 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 3 years after the time written proof of loss is required to be furnished.

### **The following provisions are added to the Enrollment Changes sub-section of the ELIGIBILITY AND ENROLLMENT section of this Certificate:**

Adoptive children may be enrolled up to 60 days from placement.

The restriction on enrolling new Dependents only during open enrollments when the Member fails to enroll them within 31 days of a life change event does not apply to Dependent children of a Member subject to a court or administrative order of support relating to the provision of health care coverage.

### **The following provisions are added to the GENERAL PROVISIONS section of this Certificate:**

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

All statements made by the Policyholder or applicant or Member shall, in the absence of fraud, be deemed representations and not warranties. No statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in a written instrument and signed by the Policyholder, a copy of which has been furnished to the Policyholder or the Certificate Holder or his/her beneficiary.



## SCHEDULE OF EXCLUSIONS AND LIMITATIONS

### EXCLUSIONS

Except as specifically provided in the Certificate, Schedules of Benefits or Riders to the Certificate, no coverage will be provided for services, supplies or charges:

1. Not specifically listed as a Covered Service on the Schedule of Benefits and those listed as not covered on the Schedule of Benefits.
2. Which are necessary due to patient neglect, lack of cooperation with the treating dentist or failure to comply with a professionally prescribed Treatment Plan.

This exclusion does not apply to Group Policies and Certificates issued and delivered in California.

3. Started prior to the Member's Effective Date or after the Termination Date of coverage with the Company, including, but not limited to multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures.
4. Services or supplies that are not deemed generally accepted standards of dental treatment.
5. For hospitalization costs.
6. That are the responsibility of Worker's 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 and Certificates 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 and Certificates issued and delivered in Texas, only services that are the responsibility the employer's liability insurance, or for treatment of any automobile related injury shall be excluded from this Plan.

7. For prescription or non-prescription drugs, vitamins, or dietary supplements.
8. Administration of nitrous oxide, general anesthesia and i.v. sedation, unless specifically indicated on the Schedule of Benefits.

9. Which are Cosmetic in nature as determined by the Company, including, but not limited to bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures.

This exclusion does not apply to Group Policies and Certificates issued and delivered in Pennsylvania for Cosmetic services required as the result of an accidental injury.

This exclusion does not apply to Group Policies issued and delivered in New Jersey for Cosmetic services for newly-born children of Members as defined in the definition of Dependent.

10. Elective procedures including but not limited to the prophylactic extraction of third molars.
11. For the following which are not included as orthodontic benefits - retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient neglect, or repair of an orthodontic appliance.
12. For congenital mouth malformations or skeletal imbalances, including, but not limited to 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 and Certificates issued and delivered in Arizona, Kentucky, and Pennsylvania this exclusion shall not apply to newly born children of Members as defined under the definition of Dependent including newly adoptive children, regardless of age.

For Group Policies issued and delivered in Colorado, Indiana, Missouri, New Jersey, and Virginia, this exclusion shall not apply to newly born children of Members as defined under the definition of Dependent.

For Group Policies issued and delivered in Colorado, this exclusion shall not apply to orthodontic or dental services for a newly born Dependent with cleft lip or cleft palate and shall be covered as listed on the Schedule of Benefits.

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33. Which are not Dentally Necessary as determined by the Company.

This exclusion does not apply to Group Policies and Certificates issued and delivered

## LIMITATIONS

The following services will be subject to limitations as set forth below:

1. Full mouth x-rays – one every three years.
2. One set(s) of bitewing x-rays per six months.
3. Periodic oral evaluation – one per six months.
4. Limited oral evaluation (problem focused) – limited to one per dentist per twelve months.
5. Prophylaxis – one per six months.
6. Fluoride treatment – one per six months through age eighteen.
7. Space maintainers - only eligible for Members through age eighteen when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not develop.
8. Prefabricated stainless steel crowns - one per tooth per lifetime for age fourteen years and younger.
9. Crown lengthening - one per tooth per lifetime.
10. Periodontal maintenance following active periodontal therapy – two per twelve months in addition to routine prophylaxis.
11. Periodontal scaling and root planing - one per two year period per area of the mouth.
12. Placement or replacement of single crowns, inlays, onlays, single and abutment buildups and post and cores, bridges, full and partial dentures – one within five years of their placement.
13. Denture relining, rebasing or adjustments - are included in the denture charges if provided within six months of insertion by the same dentist.
14. Subsequent denture relining or rebasing – limited to one every three year(s) thereafter.
15. Surgical periodontal procedures - one per two year period per area of the mouth.
16. Sealants - one per tooth per three year(s) through age ten on permanent first molar and through age fifteen on permanent second molars.
17. Pulpal therapy – once per tooth per lifetime.
18. Root canal treatment and retreatment – one per tooth per lifetime.
19. Recementations by the same dentist who initially inserted the crown or bridge during the first twelve months are included in the crown or bridge benefit, then one per twelve months thereafter; one per twelve months for other than the dentist who initially inserted the crown or bridge.
20. Replacement restorations – limited to one per twelve months.
21. Contiguous surface posterior restorations not involving the occlusal surface will be payable as one surface restoration.
22. Posts are only covered as part of a post buildup.
23. An Alternate Benefit Provision (ABP) will be applied if a 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 for the ABP.
24. Payment for orthodontic services shall cease at the end of the month after termination by the Company.
25. Consultations are limited to one per consultant, during any one period of hospitalization, when the member's dental condition requires such consultation.

