**SUBMITTAL TO THE BOARD OF DIRECTORS**
**IN-HOME SUPPORTIVE SERVICES PUBLIC AUTHORITY**
**COUNTY OF RIVERSIDE, STATE OF CALIFORNIA**

3.05C

**FROM:** Department of Public Social Services

**SUBMITTAL DATE:**
December 20, 2011

**SUBJECT:** Agreement with United Concordia Companies Inc., (UCCI) to provide dental insurance and a discount vision program for IHSS home workers.

**RECOMMENDED MOTION:** That the Board of Supervisors:

1. Approve and authorize the Chairman of the Board to sign the attached agreement with United Concordia Companies, Inc. (UCCI) for the period of July 1, 2011 through June 30, 2012 for an amount not to exceed $210,141 annually with an option to renew the agreement for four (4) additional one year periods; and
2. Authorize the Director of the Department of Public Social Services (DPSS) to administer the Agreement; and
3. Authorize the Purchasing Agent, in accordance with Ordinance No. 459, to exercise the renewal options, based on the availability of fiscal funding, and to sign amendments that do not change the substantive terms of the agreement, including amendments to the compensation provision that do not exceed the annual CPI rates.

**Continued – 2 pages in total**

Susan Loew

Susan Loew, Director
Department of Public Social Services

| FINANCIAL DATA | | | | |
|---|---|---|---|---|
| | **Current F.Y. Total Cost:** | $ 210,141 | **In Current Year Budget:** | Yes |
| | **Current F.Y. Net County Cost:** | $ 37,510 | **Budget Adjustment:** | No |
| | **Annual Net County Cost:** | $ 37,510 | **For Fiscal Year:** | 2011/12 |

**SOURCE OF FUNDS:** 49% Federal Funds; 33.15% State Funds; 17.85% Realignment Funds.

**Positions To Be Deleted Per A-30** ☐

**Requires 4/5 Vote** ☐

**C.E.O. RECOMMENDATION:** APPROVE

BY: Debra Cournoyer

**County Executive Office Signature**

FORM APPROVED COUNTY COUNSEL
BY: TAMMY V. LIEU County Counsel 12-6-11

Approved by Barbara A. Olivier
Asst. County Executive Officer/
Departm Human Resources Director

Mark Seiler, Assistant Director
County Purchasing Agent

☒ Consent ☐ Policy

☐ Consent ☐ Policy

Dep't Recomm.:

Per Exec. Ofc.:

**Prev. Agn. Ref.:**

**District:** All

**Agenda Number:** 7.1

ATTACHMENTS FILED
WITH THE CLERK OF THE BOARD

**TO:** **BOARD OF DIRECTORS** **DATE:** December 20, 2011

**SUBJECT:** Agreement with UCCI to provide dental insurance and discount vision program for IHSS home workers

**BACKGROUND (continued):**
The County Purchasing Department on behalf of Public Authority In-Home Supportive Services (IHSS), released a Request for Proposal (RFP HRARC-042) for Dental and Vision Services, mailing solicitations to eighteen (18) organizations and advertising on the County's internet site. Organizations submitted bids in response to the RFP that ranged from $210,141 to $229,000 annually.

The two bid proposals were reviewed by a team of IHSS Public Authority personnel and a member of Human Resources based on the following criteria:1) Experience and Ability; 2) Service; 3) Cost; 4) Provider Network; 5) Minimal Disruption; and 6) Similar Benefit Plan Design.

United Concordia was the lowest cost and most responsive bidder to the RFP and has shown capability to effectively administer the plan and manage costs without sacrificing quality of member satisfaction. For 40 years, United Concordia has administered dental benefit programs and is one of the largest dental insurance carriers in the country, currently administering dental benefits for 8 million members nationwide. Additionally, United Concordia has expanded their Dental Health Maintenance Organization (DHMO) network in Riverside and San Bernardino counties and, if this recommendation is approved no interruption of services, transition periods or plan implementation will be necessary.

Since 2008, United Concordia has administered the IHSS dental plan and understands the unique qualities of the State's ability to fund a portion of the health benefit (medical, dental, and vision) plan services to IHSS Home Care Providers. In spite of the uncertainty of State funding, United Concordia offered the most competitive and cost-efficient plans. United Concordia's best and final for the DHMO fully insured rate along with the discount vision program is $9.28 per member per month, for a guaranteed two year period (July 1, 2011- June 30, 2013). The 2.5% rate increase is due to overall utilization of the dental plan benefits and number of current enrollees. There are approximately 1,900 employees eligible to participate in the plan.

The Public Authority's contribution for health benefits is $0.60 per hour for all compensated hours not to exceed the agreed upon annual aggregate net County cost as outlined in the current MOU between UDWA and Public Authority.

The United Concordia contract was amended to incorporate contract terms that were better aligned with the Board's policies. As a result, the contract was filed with the Department of Insurance and was not available for submission to the Board until this time.

**FINANCIAL:** The funds for this Agreement were budgeted through the normal County budgeting process.

**ATTACHMENT(S):** Group Contract with United Concordia Dental Plan of California, Inc.

**CONCUR/EXECUTE:** County Purchasing & Fleet Services

SL:ko

# GROUP CONTRACT

**for**

**Dental Health Maintenance Organization Dental Benefits**

***UNITED CONCORDIA DENTAL PLANS OF CALIFORNIA, INC.***
***21700 Oxnard Street, Suite 500***
***Woodland Hills, CA 91367***

| | |
|---|---|
| **CONTRACTHOLDER:** | **PUBLIC AUTHORITY IHSS** |
| **GROUP POLICY NO.:** | **855191000, 855191001** |
| **EFFECTIVE DATE:** | **MARCH 1, 2008** |
| **MINIMUM PARTICIPATION NUMBER:** | **MINIMUM OF TWO CONTRACTS** |

The Contractholder and United Concordia Dental Plans of California, Inc. ("Company") will make the dental benefit plan available to eligible Subscriber(s) and their Dependents ("Members") at 12:01 AM on the Effective Date and upon the terms and conditions contained in this Group Contract. The Company will pay the benefits described in the Schedule of Benefits and Schedule of Exclusions and Limitations and any riders attached to the Combined Evidence of Coverage and Disclosure Form ("Evidence of Coverage"), subject to the Group Contract terms. The Evidence of Coverage is attached and incorporated herein by this reference. The parties shall fulfill the obligations stated herein.

Certain terms have specific meanings and are set forth in the Definitions section outlined in Section F.

United Concordia Dental Plans of California, Inc.

Daniel J. Ebisch

Authorized Officer

## CONTRACT RULES

### A. *Eligibility:*

In order to be eligible to enroll in the Plan, a Subscriber must meet the Contractholder's eligibility requirements. To be eligible to enroll as a Dependent, a person must be eligible to enroll under the Contractholder's eligibility requirements and satisfy the requirements and definitions set forth in the Evidence of Coverage.

The Company agrees that no person shall be refused enrollment or re-enrollment because of age, dental health status, genetic disorder, requirements for dental services, or the existence of a pre-existing dental condition.

During the term of this Group Contract, no change in the Contractholder's eligibility requirements, participation requirements, or Renewal Date shall be permitted to affect eligibility or enrollment unless such change is agreed to in advance by the Company.

### B. *Enrollment:*

An eligible Subscriber and his/her Dependent(s) shall become enrolled in the Plan as follows:

1) After satisfaction of Contractholder's eligibility requirements, the Subscriber must provide enrollment information including all eligible Dependents within: (a) 31 days of first becoming eligible, (b) by the Effective Date of this Group Contract, or (c) during the Contractholder's open enrollment period, or (d) as specified in any applicable Late Entrant Rider to the Certificate. Coverage for Members shall be effective on the date specified in the enrollment information.
2) Dependents may be added after the Effective Date of the Subscriber in the event of birth, marriage, adoption, court order of placement or custody or change in student status. To enroll a new Dependent, a change of enrollment must be submitted to the Company within 31 days of acquiring the Dependent. Coverage shall be effective on the date specified in the enrollment information provided to the Company, except for newly born or adoptive children. Coverage for newly born or adoptive children shall be effective as stated in the Enrollment Changes section of the Evidence of Coverage. In order for coverage of newly born or adoptive children to continue beyond the 31 day period, notification of birth or adoption and payment of the required Premium shall be furnished to the Company within the 31 day period.
3) Members not enrolled during the initial enrollment as stated under 1) or 2) above, may not be enrolled until the Contractholder's next open enrollment period unless otherwise specified in any applicable Late Entrant Rider to the Evidence of Coverage. A Subscriber who is required to provide coverage for a Dependent child pursuant to a court order, shall be permitted to enroll the Dependent child without regard to enrollment season requirements.

At a time agreed upon by the Company and the Contractholder, no more frequently than annually, an open enrollment period shall be provided in which a Subscriber may elect to enroll or disenroll him/herself and eligible Dependents under this Group Contract.

## GENERAL CONTRACT RULES

### A. *Payment of Premiums:*

In consideration of the dental benefit plan made available to the Members by the Company, the Premium listed on the Schedule of Premium is payable in accordance with such Schedule of Premium and any Riders thereto.

### B. *Term and Cancellation of Group Contract:*

This Group Contract shall begin at 12:01 A.M. on the Effective Date as stated on the front of this Group Contract. This Group Contract shall continue in effect for a term of one year, and from year to year thereafter, subject to the provisions outlined below. The basis for cancellation of this Group Contract will conform with Section 1365(a) of the Knox Keene Act. The Director may review the basis for cancellation as provided in Section 1365(b) of the Knox Keene Act.

1) Either the Contractholder or the Company may elect not to renew the Group Contract by providing written notice to the other party's most current address of record at least 31 days prior to renewal. In the absence of notice from the Contractholder of its intention not to renew, payment of the renewal Premium constitutes acceptance of the renewal.
2) The Company may terminate, or refuse to renew, this Group Contract upon default in the payment of Premium by giving to the Contractholder 31 days prior written notice to the most current address of record of such termination or nonrenewal. Notice to the Contractholder shall state the amount of Premium due. Payment of said sum prior to the date of intended termination or nonrenewal shall continue this Group Contract in full force and effect. Nonpayment of said sum prior to the expiration of the Grace Period shall result in the termination of the Plan 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. The Contractholder shall remain liable to the Company for Premiums accrued during the Grace Period.
3) If the full Premium payment is received more than 15 days after issuance of the termination notice, the Company will issue a new Group Contract together with a written notice stating clearly those respects in which the new Group Contract differs from the terminated Group Contract within 20 business days of receipt of the Premium payment.
4) The Company may terminate this Plan on any Premium due date if the Subscribers insured under this Group Contract total less than the number enrolled on the cover of this Group Contract. The Company may adjust the Premium or the Schedule of Benefits on any Premium due date if the number of Members enrolled under this Group Contract increases or decreases by 10% or if the extent or nature of the risk changes significantly. The Company will notify the Contractholder in writing to the most current address of record at least 31 days prior to the date of such adjustment or termination.
5) Coverage may also be terminated or non-renewed where there is: (a) fraud or misrepresentation by the Contractholder, or with respect to coverage of a Member, fraud or misrepresentation by the Member or the Member's representative; or (b) noncompliance with Plan provisions.
6) Notwithstanding 1) and 3) above, either the Company or the Contractholder may terminate this Plan in writing with at least 60 days advance notice.

C. ***Contractholder Obligations:***

The Contractholder agrees, in addition to any other obligations contained herein, that it shall:

1) Collect from its Subscribers any contributory portion of the Premium and notify Subscribers of any change in such contribution. Pay the Premium specified on the Schedule of Premium or renewal notice for this Group Contract for all enrolled Subscribers and Dependents who enroll for dental benefits, as reported to the Company. Premium for Members who become ineligible during the course of this Group Contract is due through the end of such month in which they become ineligible. If the Company is unable to determine from its records that a Member has become ineligible, Premium shall be due through the end of such month in which the Contractholder notifies the Company that such Member is ineligible.
2) Notify the Company as soon as possible when coverage is to be continued for ineligible Members under any state or federal law or regulation. It is the Contractholder's obligation to notify Subscribers and Dependents of their rights and any Premium due for continuation coverage under federal law.
3) At a mutually agreed upon time, send enrollment and other data required by the Company to perform its duties under this Group Contract and to determine Premium rates. All records of the Contractholder which bear on the contract including eligibility, enrollment, and payment of Premium, must be open to the Company for its inspection and to make copies at any reasonable time and with reasonable notice to the Contractholder.
4) Notify all Subscribers of the termination of coverage. Contractholder agrees to mail a true copy of the notification of cancellation to all Subscribers promptly, and provider proof of the mailing notification to all Subscribers, including the date of the mailing.

## D. Company Obligations:

In consideration of the Contractholder's payment of the Premium rates set forth in GENERAL CONTRACT RULES (A) of this Group Contract, the Company shall perform the following administrative functions necessary to ensure the provision of benefits for the Contractholder and its Members.

1) Unless otherwise agreed to in writing by both parties, Company will notify the Contractholder on or before the 10th of the calendar month preceding the payment period shown on the Application of the Premium due and the Members on its eligibility file.
2) Process claims and encounters in accordance with this Group Contract and the Evidence of Coverage using the eligibility data provided by the Contractholder.
3) Issue explanations of benefits paid or denied under this Group Contract to Members including any applicable Copayments, Deductibles, Limitations, Maximums, or reasons for denial.
4) Provide a network of Primary Dental Offices from which Members obtain services and referrals to Specialty Care Dentists. The Company will provide all attendant network administration including but not limited to the distribution of Primary Dental Offices information to the Contractholder or its Members and eligibility lists to Primary Dental Offices, credentialing, processing of Primary Dentist selections and approval of facility to transfers, direct payment to Primary Dental Offices, network quality assurance, investigation of complaints and grievances, and approval of out-of-network care.
5) Provide an Evidence of Coverage for each Subscriber which describes the Members' coverage.
6) Respond to Member, dentist and Contractholder telephone and written inquiries and complaints.
7) Maintain adequate records of claims submitted under this Group Contract. Such records are owned by and proprietary to the Company.
8) Disclose claim or eligibility records only as allowed or required by law. The Company maintains physical, electronic, and procedural safeguards to guard claims and eligibility information from unauthorized access, use, and disclosure.
9) Provide the pro rata portion, in the event of a terminated Contract, of unused Premium less claims costs to Contractholder within 30 days except in the case of fraud or deception in the use of services or facilities of the Plan or knowingly permitting such fraud or deception.
10) Provide written notice for a change in Premium, benefits, termination, or cancellation 31 days in advance as outlined in the "Term and Cancellation of the Group Contract" Section.
11) Be subject to the requirements of Chapter 2.2 of Division 2 of the Code and Chapter 1 of Title 28 of the California Code of Regulations, any provision required to be in the Group Contract by either of the above shall bind the Company whether or not provided in the Group Contract.
12) Hold Members harmless for Covered Services, except for Copayments, in the event of provider termination until the services being rendered to the Member by such provider are completed, unless Company makes reasonable and medically appropriate provision for the assumption of such services by and In-Network Dentists.
13) Provide written notice within 31 days of any termination or breach of contract by, or inability to perform of any In-Network Dentist that may materially and adversely affect and thereby harm Members for Covered Services under the Plan.

**E. General Provisions:**

1) This Group Contract shall be governed by the laws of California.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-866-357-3304 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

2) This Group Contract consists of the attached Schedule of Premium, Evidence of Coverage, Schedule of Benefits, Schedule of Exclusions and Limitations, and the Application for Group Dental Insurance, including any riders, addenda and/or endorsements to the previously mentioned forms. This Group Contract represents the entire agreement between the Contractholder and the Company with respect to the subject matter. The failure of any section or subsection of this Group Contract shall not affect the validity, legality and enforceability of the remaining sections hereof. A copy of the Application shall be attached to the Group Contract when issued.
3) No statement of the Contractholder shall be used in any contest of coverage under this Group Contract. There will be no contest of the validity of the Group Contract, except for not paying Premiums, after it has been in force two (2) years after the Effective date. All statements made by the Contractholder or by any insured Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in writing and signed by the Contractholder. No written statement made by any person insured shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary or personal representative.
4) Each change in the Premium or Schedule of Benefits shall be proposed by the Company to the Contractholder in writing to the most current address of record at least 31 days prior to the Renewal Date. Each change in Premium shall become effective on the date this Group Contract renews in accordance with General Contract Rules (B). For Group Contracts issued and delivered in Florida, the amendment must be proposed at least 45 days prior to the Renewal Date.

5) The Group Contract may be amended, at any time, without the consent of the insured Members or of anyone else with a beneficial interest in it. An amendment can be proposed by either party in writing to the other's most current address of record at least 31 days in advance of when the proposed amendment would take effect. The amendment and effective date must be mutually agreed to by both parties. No change other than a change in Premium in this Group Contract will be valid unless shown in an endorsement signed by a designated officer of the Company or an amendment signed by the Contractholder and a designated officer of the Company. However, a change in the Group Contract may be made by an amendment which is signed by only a designated officer of the Company if the amendment reflects a change in the Group Contract that has been automatically made to satisfy the requirements of any state or federal law that applies to the Group Contract. Payment of Premium will confirms acceptance of the amendment. An amendment will not affect a claim incurred prior to the effective date of the change.
6) Only a duly designated officer of the Company has the authority to: (a) waive any conditions or restrictions of the Group Contract; (b) extend the time in which a Premium may be paid; (c) make or change a contract; (d) bind the Company by a promise or representation or by information given or received. An Agent of the Company is not an officer. No agent has authority to change this Contract or to waive any of its provisions.
7) Notices to the Company shall be sent to:

United Concordia Dental Plans of California, Inc.
21700 Oxnard Street, Suite 500
Woodland Hills, CA 91367

F. **Definitions:**

| | |
|---|---|
| **Combined Evidence of Coverage and Disclosure Form** | This document, and its riders, schedules, addenda and/or endorsements if any, which describe the coverage purchased from ("Evidence of Coverage") the Company by the Contractholder. |
| **Company** | United Concordia Dental Plans of California, Inc. |
| **Copayments** | Those charges set forth in the Schedule of Benefits that the Member is responsible to pay the treating dentist. |
| **Covered Service(s)** | A service or supply specified in the Schedule of Benefits for which benefits will be covered subject to the Benefits section of this Evidence of Coverage, when rendered by network dentists in accordance with the terms of this Evidence of Coverage. |
| **Contractholder** | Organization that executes the Group Contract. |
| **Dependent(s)** | As defined in the Evidence of Coverage. |
| **Effective Date** | The date on which the Group Contract begins or coverage of enrolled Member(s) begins. |
| **Grace Period** | A period of no less than 31 days after Premium payment is due under the Contract, in which the Contractholder may make such payment and during which the protection of the Group Contract continues, subject to the payment of Premium by the end of the Grace Period. |
| **In-Network Dentist** | A primary dentist or specialty care dentist that has a contract with the Company. |
| **Member(s)** | Subscriber and their Dependent(s). |
| **Plan** | Dental benefits pursuant to this Evidence of Coverage and attached Schedule of Exclusions and Limitations Schedule of Benefits. |
| **Premium** | Payment that the Contractholder must remit to the Company in exchange for coverage of the Contractholder's Members. |
| **Renewal Date** | The date on which the Group Contract renews. Also known as anniversary date. |
| **Schedule of Benefits** | Attached summary of Covered Services and Copayments applicable to benefits payable under the Plan. |
| **Schedule of Exclusions and Limitations** | Attached list of Exclusions and Limitations applicable to benefits, services, supplies or changes under the Plan. |
| **Subscriber** | An eligible 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". |
| **Termination Date** | The date on which the dental coverage ends for a Member or the Group Contract terminates. |

**SCHEDULE OF ATTACHED FORMS**

This Schedule lists the Certificate of Coverage, including any riders and/or endorsements, Schedule of Exclusions and Limitations, and Schedule of Benefits attached to and made a part of this Group Contract.

| Group # | Title of Form | Form Number |
|---|---|---|
| 855191000, 855191001 | Schedule of Premium | CA9803L (07/04) SP-1-C+ |
| | | |
| | | |
| | | |
| | | |
| | | |

**ACCEPTANCE OF GROUP CONTRACT**

**CONTRACTHOLDER:** **PUBLIC AUTHORITY IHSS**

**ADDRESS:** **12125 DAY STREET**
**SUITE S-101**
**MORENO VALLEY, CA 92557**

**GROUP POLICY NO.:** **855191000, 855191001**

This Group Contract is hereby accepted. This acceptance Application is made in duplicate. One is to be attached to the Group Contract; the other is to be returned to the Company in the enclosed envelope.

It is agreed that this Acceptance Application supersedes any previous Group Contract.

*Witness:* _____
*(to be signed by Agent where required by law)*

*Date:* _____

_____
*(Full Corporate Name of Applicant)*

*Dated at:* _____
*(City and State)*

*By:* _____
*(Signature)*

_____
*(Please print name)*

*Title:* _____

CA9803L (10/08)
AA-1

**SCHEDULE OF PREMIUM – PROSPECTIVE RATING METHOD**

The Premium is determined from the rates multiplied by the number of Subscribers and/or Dependents as described below.

The Contractholder will remit the Premium on behalf of its Subscribers on the due date specified on each notice of Premium due from Company or on a monthly date otherwise agreed to by both parties.

| | Rates |
|---|---|
| **Subscriber** | $ 9.28 |

Premium rates are guaranteed for the period from July 1, 2011 to June 30, 2013.

All surpluses are the property of Company. All deficits shall be paid for out of Company reserves.

**AMENDMENT TO GROUP CONTRACT FOR DENTAL HEALTH MAINTENANCE ORGANIZATION DENTAL BENEFITS**

BY AND BETWEEN

UNITED CONCORDIA DENTAL PLANS OF CALIFORNIA, INC.
AND
COUNTY OF RIVERSIDE

This Amendment to the Group Contract for Dental Health Maintenance Organization Dental Benefits ("Amendment" or "Amendment to Group Contract") is made effective as of **July 1, 2011** (the "Effective Date") by and between United Concordia Dental Plans of California, Inc. (hereinafter referred to as "Company"), a California corporation, and the County of Riverside (hereinafter referred to as "County of Riverside" or "Contractholder"), a political subdivision of the State of California and identified as the Contractholder Public Authority IHSS in the Group Contract. Company and Contractholder may be referred to collectively as "parties" and separately as "party."

This Amendment supplements and amends the Group Contract for Dental Health Maintenance Organization Dental Benefits (Group Policy Nos. 855191000, 855191001) dated March 1, 2008 ("Group Contract") between Company and Contractholder.

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein, and for good and valuable consideration, Company and Contractholder agree as follows:

**1. Defined Terms.** Unless otherwise defined herein, the capitalized terms used herein shall have the same meaning set forth in the Group Contract.

**2. Amendments.**

2.1 Paragraph numbered as "1)" of Section B "Term and Cancellation of Group Contract" under General Contract Rules on page 3 of the Group Contract is deleted in its entirety and replaced with the following:

> "This Group Contract shall continue in effect for a term of one year beginning July 1, 2011 through June 30, 2012, with the option to renew for one additional year not to exceed June 30, 2013. Unless terminated earlier, this Group Contract may be renewed by written amendment signed by the Contractholder and Company."

2.2 Paragraph numbered as "4)" of Section B "Term and Cancellation of Group Contract" under General Contract Rules on page 3 of the Group Contract is deleted in its entirety and replaced with the following:

> "The Company may adjust the Premium or the Schedule of Benefits on any Premium due date if the number of Members enrolled under the Group Contract increases or decreases by 10% of Two Thousand (2,000) or if the extent or nature

of the risk changes significantly. The Company will notify the Contractholder in writing to the most current address of record at least 31 days prior to the date of such adjustment."

2.3 Paragraph numbered as "2)" of Section E "General Provisions" on page 6 of the Group Contract is deleted in its entirety and replaced with the following:

"Entire Agreement. This Group Contract, the attached Schedule of Premium, Evidence of Coverage, Schedule of Benefits, Schedule of Exclusions and Limitations, and Application for Group Dental Insurance, including any riders, addenda and/or endorsements to the previously mentioned forms, and the Amendment to Group Contract contain the entire understanding of Company and Contractholder with respect to the subject matter hereof and it incorporates all of the covenants, conditions, promises, and agreements exchanged by the parties hereto with respect to such matter. This Group Contract supersedes any and all prior or contemporaneous negotiations, agreements, or communications, whether written or oral, between Company and Contractholder with respect to the subject matter of this Group Contract. A copy of the Application for Group Dental Insurance shall be attached to the Group Contract when issued."

2.4 At Section E "General Provisions" on page 6 of the Group Contract, the following provisions are added:

"8) Public Authority IHSS. Company and Contractholder acknowledge and agree that the terms "Public Authority IHSS" and/or "Contractholder" as used in this Group Contract means the County of Riverside, a political subdivision of the State of California.

9) Amendments. This Group Contract may be modified by Contractholder and Company pursuant to mutual written Amendments. Amendments shall require the formal approval of the Board of Supervisors for Contractholder to be effective, except as expressly provided herein.

Amendments which shall not require the formal approval of the Board of Supervisors for Contractholder to be effective may include, but shall not be limited to, amendments of rate adjustment and amendments to the policies and procedures, and/or operations as required by new laws and regulations, or by a court of competent jurisdiction. Such amendments shall be effective upon the date of approval by Contractholder's Executive Director or Assistant CEO/Director of Human Resources.

10) Waiver of Default. The waiver by either party of any one or more defaults shall not be construed as a waiver of any other or future defaults, under the same or different terms, conditions or covenants contained in this Group Contract.

11) Notices. Any notice required to be given under this Group Contract shall be in writing and either delivered personally or by United States mail at the addresses set forth below or at such other addresses as the parties may hereafter designate:

If to Contractholder:

In-Home Support Services Public Authority
Riverside County DPSS
12125 Day Street, Suite S101
Moreno Valley, CA 92557
Attn: IHSS Public Authority Executive Director

If to Contractor:

United Concordia Dental Plans of California, Inc.
21700 Oxnard Street, Suite 500
Woodland Hills, CA 91367

All notices shall be deemed given on the date of delivery if delivered personally or on the third business day after such notice is deposited in the United States mail, addressed and sent as provided above.

12) Venue. All actions and proceedings arising in connection with this Group Contract shall be tried and litigated exclusively in the state and federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Riverside, State of California.

13) Government Claims Act. The provisions of the Government Claims Act (Government Code section 900 et seq.) must be followed first for any disputes arising under this Group Contract.

14) Company's Responsibility. Company shall maintain and provide adequate records and information as reasonably necessary to properly administer the Group Contract consistent with state and federal law. Such records shall be retained by Company for at least five (5) years from the close of Contractholder's fiscal year in which this Group Contract is in effect. This obligation is not terminated upon a termination of the Group Contract, whether by rescission or otherwise.

15) Independent Contractor. The relationship between Company and Contractholder is an independent contractor relationship. Neither Company nor its employee(s) and/or agent(s) shall be considered to be an employee(s), and/or agent(s) of Contractholder. Contractholder nor any employee(s) and/or agent(s) of Contractholder shall be considered to be an employee(s) and/or agent(s) of Company. None of the provisions of this Group Contract shall be construed to create a relationship of agency, representation, joint venture, ownership, control

or employment between the parties other than that of independent parties contracting for the purposes of effectuating this Group Contract.

16) Invalidity and Severability. If any provision of this Group Contract is found to be invalid or unenforceable by any court, such provision shall be in effect only to the extent that it is not in contravention of applicable laws without invalidating the remaining provisions hereof.

17) Limitations of Severability. In the event the removal of a provision rendered invalid or unenforceable or declared null and void had the effect of materially altering the obligations of either party in such manner as to cause serious financial hardship to such party, the party so affected shall have the right to terminate this Group Contract upon providing thirty (30) days prior written notice to the other party.

18) Time is of the Essence. Time shall be of the essence of each and every term, obligation, and condition of this Group Contract.

19) Conflict of Interest. The parties hereto and their respective employees or agents shall have no interest, and shall not acquire any interest, direct or indirect, which shall conflict in any manner or degree with the performance of services required under this Group Contract.

20) Assignment. Neither party shall, without prior written consent of the other party, assign any duties or rights under this Group Contract. Any assignment in contravention of this paragraph shall constitute a material breach of this Group Contract and shall be void.

21) Licenses. Company shall maintain any professional licenses required by the laws of the State of California at all times while performing services under this Group Contract.

22) Provision of Information. Company shall provide Contractholder and/or governmental agencies with such data and other information regarding the rendition of services as may be reasonably requested or as may be otherwise required for compliance with applicable regulatory and disclosure requirements. Company shall execute such additional verifications or documents as may be required by law or regulation.

23) Records open for Inspection. All books, records and papers of Company or subcontractor of Company relating to the performance of this Group Contract must be open to inspection and copying during normal business hours by the Contractholder, or state and/or federal regulators. Records shall include, without limitation, Member records (subject to applicable state and federal law governing the confidentiality of medical records), and/or financial records pertaining to the cost of operations and income received for services rendered to Members. Such

records shall be made available at all reasonable times upon reasonable request by Contractholder. Company or subcontractor of Company shall maintain its books and records in accordance with general standards for books and record keeping.

24) Insurance.

Company's Insurance Coverage. Without limiting or diminishing Company's obligation to indemnify or hold the Contractholder harmless, Company shall procure and maintain or cause to be maintained, at its sole cost and expense, the following insurance coverage during the term of this Group Contract.

Workers' Compensation. If Company has employees as defined by the State of California, Company shall maintain statutory Workers' Compensation Insurance (Coverage A) as prescribed by the laws of the State of California. Policy shall include Employers' Liability (Coverage B) including Occupational Disease with limits not less than $1,000,000 per person per accident. The policy shall be endorsed to waive subrogation in favor of the County of Riverside.

Commercial General Liability. Commercial General Liability insurance coverage, including but not limited to, premises liability, contractual liability, products and completed operations liability, personal and advertising injury and cross liability coverage, covering claims which may arise from or out of Company's performance of its obligations hereunder. Policy shall name the County of Riverside, its Agencies, Districts, Special Districts, Court and Departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured. Policy's limit of liability shall not be less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this Group Contract or be no less than two (2) times the occurrence limit.

Vehicle Liability. If vehicles or mobile equipment is used in the performance of the obligations under this Group Contract, then Company shall maintain liability insurance for all owned, non-owned or hired vehicles so used in an amount not less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this Group Contract or be no less than two (2) times the occurrence limit. Policy shall name the County of Riverside, its Agencies, Districts, Special Districts, Court and Departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured.

Professional Liability Insurance. Company shall maintain Professional Liability Insurance providing coverage for Company's performance of work included within this Group Contract, with a limit of liability of not less than $1,000,000 per occurrence and $2,000,000 annual aggregate. If Company's Professional Liability Insurance is written on a claims made basis rather than an occurrence basis, such

insurance shall continue through the term of this Group Contract and Company shall purchase at his sole expense either 1) an Extended Reporting Endorsement (also known as Tail Coverage); or 2) Prior Dates Coverage from new insurer with a retroactive date back to the date of, or prior to, the inception of this Group Contract; or 3) demonstrate through Certificates of Insurance that Company has maintained continuous coverage with the same or original insurer. Coverage provided under items; 1), 2) or 3) will continue for a period of two (2) years beyond the termination of this Group Contract.

General Insurance Provisions - All Lines.

1. Any insurance carrier providing insurance coverage hereunder shall be admitted or authorized by the State of California and have an A M BEST rating of not less than A-: VIII (A:8) unless such requirements are waived, in writing, by the Contractholder's Risk Manager. If the Contractholder's Risk Manager waives a requirement for a particular insurer, such waiver is only valid for that specific insurer and only for one policy term.
2. Company's insurance carrier(s) must declare its insurance deductibles or self-insured retentions.
3. Company shall cause Company's insurance carrier(s) to furnish the County of Riverside with either 1) a properly executed original Certificate(s) of Insurance and copies of Endorsements effecting coverage as required herein. Further, said Certificate(s) and policies of insurance shall contain the covenant of the insurance carrier(s) that endeavor to provide thirty (30) days written notice shall be given to the County of Riverside prior to any material modification, cancellation, expiration or reduction in coverage of such insurance. *Company shall not commence operations until the Contractholder has been furnished original Certificate(s) of Insurance and copies of endorsements. An individual authorized by the insurance carrier to do so on its behalf shall sign the original endorsements for each policy and the Certificate of Insurance.*
4. It is understood and agreed to by the parties hereto and the insurance company(s), that the Certificate(s) of Insurance and policies shall so covenant and shall be construed as primary insurance, and the Contractholder's insurance and/or deductibles and/or self-insured retention's or self-insured programs shall not be construed as contributory.
5. The Contractholder's Reserved Rights--Insurance. If, during the term of this Group Contract or any extension thereof, there is a material change in the scope of services; or, there is a material change in the equipment to be used in the performance of the scope of work which will add to additional exposures (such as the use of aircraft, watercraft, cranes, etc.); or, the term of this Group Contract including any extensions thereof exceeds five (5) years the Contractholder reserves the right to adjust the types of insurance required under this Group Contract and the monetary limits of liability for the insurance coverage's currently required herein, if; in the

Contractholder Risk Manager's reasonable judgment, the amount or type of insurance carried by Company has become inadequate.

6. The insurance requirements contained in this Group Contract may be met with a program(s) of self-insurance acceptable to the Contractholder.

25) Hold Harmless/Indemnification.

Company shall indemnify and hold harmless Contractholder, its Agencies, Districts, Special Districts and Departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives (the "Contractholder's Indemnified Parties") from any liability whatsoever, including but not limited to, property damage, bodily injury, or death, based or asserted upon any services by Company, its directors, officers employees, subcontractors, agents or representatives arising out of or in any way relating to this Group Contract. The preceding indemnification provision shall not apply in the event any of the named parties subject to indemnification pursue, alone or in conjunction with other parties, any legal action in court or other jurisdiction against Company for any liability whatsoever based upon or asserted upon any services of Company, its directors, officers, employees, subcontractors, agents or representatives. Company shall defend at its sole expense and pay all costs and fees, including but not limited to, attorney fees, cost of investigation, defense and settlements or awards, on behalf of the Contractholder's Indemnified Parties in any claim or action based upon such liability.

With respect to any action or claim subject to indemnification herein, Company shall, at their sole cost, have the right to use counsel of their choice and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of the Contractholder's Indemnified Parties; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes Company's obligation to indemnify as set forth herein. Company's obligation to indemnify, defend and hold harmless Contractholder shall be subject to Contractholder having given Company written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and reasonable assistance, at Company's expense, for the defense or settlement thereof.

Company's obligations hereunder shall be satisfied when they have provided the Contractholder's Indemnified Parties the appropriate form of dismissal relieving the Contractholder's Indemnified Parties from any liability for the action or claim involved. The specified insurance limits required in this Group Contract shall in no way limit or circumscribe Company's obligation to indemnify as set forth herein.

26) Conflicts. In the event any provisions in the Amendment to Group Contract conflict or appear inconsistent with any provisions in the Group Contract, the attached Schedule of Premium, Evidence of Coverage, Schedule of Benefits,

Schedule of Exclusions and Limitations, and/or the Application for Group Dental Insurance, including any riders, addenda and/or endorsements to the previously mentioned forms, the provisions of the Amendment to Group Contract shall prevail and control."

3. **Full Force and Effect.** Except as supplemented and amended by this Amendment to Group Contract, all other terms and conditions of the Group Contract shall remain in full force and effect.

4. **Certification of Authority to Execute this Amendment.** Company certifies that the individual signing below has the authority to execute this Amendment to Group Contract on behalf of Company, and may legally bind Company to the terms and conditions of this Amendment to Group Contract.

[Signatures continued on next page]

**IN WITNESS WHEREOF**, the parties hereto have caused their duly appointed representatives to execute this Amendment to Group Contract as of the Effective Date.

**ATTEST:**
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: _____

**COUNTY OF RIVERSIDE:**

By: _____
Chairman, Board of Supervisors

Date: _____

Approved as to Form:
Pamela J. Walls
County Counsel

By: _____
Deputy County Counsel

**COMPANY: United Concordia Dental Plans of California, Inc., a California corporation**

By: _____

Printed Name: Laurie Laspina

Title: Divisional V.P.

Date: 11/22/2011

# UNITED CONCORDIA

Insuring America's Dental Health

August 18, 2011

Group Administrator
Public Authority IHSS
12125 Day Street
Suite S 101
Moreno Valley, CA 92557

Dear Group Administrator:

Your group recently had a benefit change to its dental coverage with United Concordia effective July 1, 2011. Please destroy any old Certificates of Coverage/Insurance you may have on hand.

In an effort to more efficiently administer your group, United Concordia has placed the Certificates of Coverage/Insurance on our website at www.unitedconcordia.com under the feature, *My Dental Benefits*. Enclosed, please find a supply of postcards for your employees explaining how to access their Certificates of Coverage/Insurance online.

If you have questions about your dental benefit program, please contact your Sales/Service Representative. Other questions may be referred to United Concordia's website at www.unitedconcordia.com or to our Customer Service Department at 866-357-3304.

We thank you for your continued relationship with United Concordia. Please know that it is our sincere pleasure to serve you and your members.

Sincerely,

Chad T Cressler
Director, Account Installation and Conversion Services

UNITED CONCORDIA
Insuring America's Dental Health

You have a right to language assistance services at no charge to you, including translation of certain plan documents in Spanish and interpretation in any language regarding your dental treatment. If you need language assistance for dental care or if you want to tell us your spoken and written language preference, please call United Concordia at **(866) 357-3304** or visit our Web site at www.unitedconcordia.com or inform your dentist.

Usted tiene derecho a recibir servicios de asistencia idiomática sin cargo alguno, incluso a la traducción de ciertos documentos del plan al español e interpretación a cualquier idioma en lo que respecta a su tratamiento dental. Si necesita asistencia idiomática durante su atención dental o quiere indicarnos en qué idioma prefiere que se le hable y escriba, llame a United Concordia al **(866) 357-3304**, visite nuestro sitio de Internet en www.unitedconcordia.com o informe a su dentista.

# United Concordia Dental Plans of California, Inc.

*21700 Oxnard Street, Suite 500*
*Woodland Hills, CA 91367*
*866-357-3304*
www.unitedconcordia.com

## COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of this dental Plan. The Group dental plan contract must be consulted to determine the exact terms and conditions of coverage.

The Combined Evidence of Coverage and Disclosure Form discloses the terms and conditions of coverage and the applicant has a right to view the evidence of coverage prior to enrollment.

Individuals with special health care needs should read those sections that apply to them.
A specimen copy of the Plan contract will be furnished on request.

Your Plan Benefits may differ from the coverage outlined in this brochure. Please refer to any inserts enclosed with this brochure.

If you belong to a group with 50 or less employees, please see the Health Plan Benefit and Coverage Matrix insert.

**Please read the following information so you will understand how this program works and how benefits may be obtained.**

# EVIDENCE OF COVERAGE

## INTRODUCTION

This Evidence 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 for You and any enrolled Dependents is paid and obligations under the Group Contract are satisfied. In the event of conflict between this Evidence of Coverage and the Group Contract, the Group Contract will rule. This Evidence of Coverage is not a summary plan description under the Employee Retirement Income Security Act (ERISA).

If You have questions about Your coverage or benefits, or for questions regarding general information, Concordia Plus Dentist availability or Benefit information please call our Customer Service Department toll-free at:

866-357-3304

You may also log on to our website at:

www.unitedconcordia.com

Claim forms should be sent to:

United Concordia Companies, Inc.
PO Box 10194
Van Nuys, CA 91410

## TABLE OF CONTENTS



ATTACHED:

SCHEDULE OF BENEFITS
SCHEDULE OF EXCLUSIONS AND LIMITATIONS

## DEFINITIONS

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

**Combined Evidence of Coverage and Disclosure Form ("Evidence of Coverage")** — This document, and its riders, schedules, addenda and/or endorsements, if any, which describe the coverage purchased from the Company by the Contractholder.

**Company** — United Concordia Dental Plans of California, Inc. Also referred to as "We", "Our" or "Us".

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

**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.

**Copayments** — Those charges set forth in the Schedule of Benefits that the Member is responsible to pay the treating dentist.

**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 the Schedule of Benefits for which benefits will be covered subject to the Benefits section of this Evidence of Coverage, when rendered by network dentists in accordance with the terms of this Evidence of Coverage.

**Dental Emergency** — Services that diagnose and treat a dental condition, which is manifested by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate dental attention could reasonably be expected to result in any of the following: (a) Placing the health of the individual in serious jeopardy, (b) Serious impairment of the bodily functions, or (c) Serious dysfunction of any bodily organ or part.

**Dentally Necessary** — A dental service or procedure 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.

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

(a) until the end of the month which he/she reaches age 19; or
(b) until the end of the month which he/she reaches age 23 if he/she is a full-time student at an accredited educational institution and chiefly reliant upon the Subscriber 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 Subscriber for maintenance and support.

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|---|---|
| **Effective Date** | The date on which the Group Contract begins or coverage of enrolled Member(s) 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 experimental or investigative treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Company determines is not the currently acceptable standard of care. |
| **Grace Period** | A period of no less than 31 days after Premium payment is due under the Contract, in which the Contractholder may make such payment and during which the protection of the Group Contract continues, subject to the payment of Premium by the end of the Grace Period. |
| **Group Contract** | The agreement between the Company and the Contractholder, under which the Subscriber is eligible to enroll. |
| **In-Network Dentist** | A Primary Dental Office or a Specialty Care Dentist. |
| **Limitation(s)** | The maximum frequency or age limit that restricts a Covered Service set forth in the Schedule of Exclusions and Limitations. |
| **Maximum Allowable Charge** | The maximum amount the Plan will allow for a specific Covered Service. Maximum Allowable Charges may vary depending upon the contract between the Company and the particular dentist rendering the service. Maximum Allowable Charges for Covered Services rendered by Out-of-Network Dentists may be the same or higher than such charges for Covered Services rendered by In-Network Dentists in order to help limit out-of-pocket costs of Members choosing Out-of-Network Dentists. |
| **Member(s)** | Subscriber and their Dependent(s). |
| **Out-of-Network Dentist / Non-Participating Provider** | A general or specialty care dentist who has not signed a contract with the Company. |
| **Plan** | Dental benefits pursuant to this Evidence of Coverage and attached Schedule of Exclusions and Limitations Schedule of Benefits. |
| **Premium** | Payment that the Contractholder must remit to the Company in exchange for coverage of the Contractholder's Members. |
| **Primary Dental Office/Provider** | Approved office of a Primary Dentist who has executed a contract with the Company and who offers dental services to Members. |
| **Primary Dentist** | A general dentist whose office has executed a contract with the Company, under which he/she agrees to provide those dental services listed in the Schedule of Benefits 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 Copayments applicable to benefits payable under the Plan. |
| **Schedule of Exclusions and Limitations** | Attached list of Exclusions and Limitations Applicable to benefits, services, supplies or changes under the Plan. |

| | |
|---|---|
| **Specialty Care Dentist** | A specialized dentist who is qualified in one of the specialty areas of periodontics, oral surgery, orthodontics, endodontics and pediatrics and who has executed a contract with the Company to accept negotiated fees plus any applicable Copayments, as payment in full for Covered Services provided to Members. |
| **Subscriber** | An eligible 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". |
| **Terminated Provider** | A doctor that formerly delivered services under contract that is no longer associated with the Plan. |
| **Termination Date** | The date on which the dental coverage ends for a Member or the Group Contract terminates. |

## ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

### New Enrollment

If You have already satisfied Your Group's eligibility requirements when the Group Contract begins and Your enrollment information is supplied to Us, Your coverage and Your Dependents' coverage will begin on the Effective Date of the Group Contract provided We receive the Premium.

If You join the Group or become employed after the initial Effective Date of the Group Contract, in order to be eligible to enroll, You must first satisfy any eligibility requirements of Your Group. Your Group will inform You of these requirements.

You must supply the required enrollment information on Yourself and Your Dependents within 31 days of the date You meet these requirements. Your Dependents must also meet the requirements detailed in the definition of Dependent in the Definitions section of this Evidence of Coverage.

Your coverage and Your Dependents' coverage will begin on the date specified in the enrollment information supplied to Us provided Premium is paid.

The Company is not liable to pay benefits for any services started prior to a Member's Effective Date of coverage. Multi-visit procedures are considered "started" when the procedure cannot be undone or reversed. 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.

### Enrollment Changes

After Your initial enrollment, there are certain life change events that permit You to add Dependents. These events are:

- birth of a child;
- adoption of a child;
- court order of placement or custody of a child;
- change in student status for a child;
- marriage of the Subscriber;

To enroll a new Dependent as a result of one of these events, You must notify Your Group and supply the required enrollment change information within 31 days of the date You acquired the Dependent. The Dependent must meet the requirements detailed in the definition of Dependent in the Definitions section of this Evidence of Coverage.

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 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 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 31 day period, the child's enrollment information must be provided to Us and the required Premium must be paid within the 31 day period.

For an enrolled Dependent child who is a full-time student, evidence of his/her student status and reliance on You for maintenance and support must be furnished to Us within 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 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 attains the limiting age for students. 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. These events include:

- death of the Subscriber or a Dependent; or
- divorce or dissolution of domestic partnership of the Subscriber; or
- for a child, reaching the limiting age specified in the definition of Dependent;

### Late Enrollment

If You or Your Dependents are not enrolled within 31 days of initial eligibility or a life change event, You or Your Dependents cannot enroll until the next open enrollment period conducted for Your Group unless otherwise required by applicable state or federal law or permitted by Your Group under the rules of its benefit plans. If You are required to provide coverage for a Dependent child pursuant to a court order, You will be permitted to enroll the Dependent child without regard to enrollment season restrictions.

## HOW THE DENTAL PLAN WORKS

### Facilities

The Primary Dental Office is the principal facility under this Plan. To determine Your Primary Dental Office, refer to the Choice of Providers section of this Evidence of Coverage.

### Choice of Providers

When You enroll for dental coverage, You must select a Primary Dental Office for Yourself and Your Dependents. Your Dependents do not have to choose the same office as Yours or each others'. If You or Your Dependents do not select an office at enrollment, You will be assigned to an office in a location convenient to Your home zip code. The Primary Dental Office(s) will be notified of Your selection or assignment.

To find a Primary Dental Office, visit *Find a Dentist* on Our website at www.unitedconcordia.com or call Our Interactive Voice Response System at the toll-free number in the Introduction section of this Evidence of Coverage, or refer to the Primary Dentist list in Your enrollment materials.

Once enrolled, You will receive an ID Card or other notification indicating Your contract ID number, Plan number and Group number, the names of the Primary Dental offices You and Your Dependents selected or that were assigned by Us. When You call the office to schedule an appointment, let the office know You have United Concordia coverage. When You visit the dental office, present Your ID card or let the office know Your ID number, Plan number and Group number. If Your dentist has questions about Your eligibility or benefits, instruct the office to call Our Interactive Voice Response System toll-free or visit *Dental Inquiry* on Our website at www.unitedconcordia.com.

**WARNING: You must go to Your Primary Dental Office or obtain a referral from Your Primary Dental Office to an In-Network dentist to have coverage under this Plan. If You have services performed by an Out-of-Network Dentist, services will not be covered under this Plan. The only exceptions are if You have a Dental Emergency or if a Primary Dentist or Specialty Care Dentist is not available in Your area. See the section entitled Dental Emergency for details on this situation.**

### Subsequent Providers

You or Your Dependents may request to change Primary Dental Offices at any time. To make a change, call our Customer Service center toll-free at the number in the Introduction section of this Evidence of Coverage or visit Our website at www.unitedconcordia.com. You will be informed of the date Your

transfer will become effective. The newly selected office will also be notified. Your new provider must be effective prior to seeking services from the new Primary Dental Office.

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.

## Provider Reimbursement

We reimburse Your Primary Dental Office on a prepaid basis for Members enrolled in their offices. Primary Dental Offices may also receive additional payment for Covered Services as services are provided under the Plan.

Specialty Care Dentists are reimbursed a Maximum Allowable Charge for Covered Services eligible for referral. No further incentives or financial bonuses are provided to In-Network Dentists. If You who wish to obtain further information on provider reimbursement You may contact the Customer Service toll-free number on the front of this Evidence of Coverage.

## Continuity of Care

Current Members:
Current Members may have the right to the benefit of completion of care with their Terminated Provider for certain specified dental conditions. Please call the Plan at 866-357-3304 to see if You may be eligible for this benefit. You may request a copy of the Plan's Continuity of Care Policy. You must make a specific request to continue under the care of Your Terminated Provider. We are not required to continue Your care with that provider if You are not eligible under our policy or if We cannot reach agreement with Your Terminated Provider on the terms regarding Your care in accordance with California law.

New Members:
A New Member may have the right to the qualified benefit of completion of care with their Non-participating Provider for certain specified dental conditions. Please call the Plan at 866-357-3304 to see if You may be eligible for this benefit. You may request a copy of the Plan's Continuity of Care Policy. You must make a specific request to continue under the care of Your current provider. We are not required to continue Your care with that provider if You are not eligible under our policy or if We cannot reach agreement with Your provider on the terms regarding Your care in accordance with California law. This policy does not apply to new Members of an individual subscriber contract.

## Referrals

The Primary Dental Office will coordinate dental care for You and Your Dependents. There are no claim forms required from You. In order for dental services to be covered, care must be provided by Your assigned Primary Dentist, or by a Specialty Care Dentist to whom You have a written referral from Your Primary Dentist. The only exceptions are if You have a Dental Emergency or if a Primary Dentist or Specialty Care Dentist is not available in Your area. See the next section entitled Dental Emergency for details on this situation.

When specialty care such as surgical treatment of the gums or a root canal is needed, the Primary Dentist may perform the procedure or can 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. Referral is limited to endodontic, orthodontic, periodontic, oral surgery, and pediatric 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 Evidence of Coverage or log onto My Dental Benefits at www.unitedconcordia.com.

## Dental Emergency

A Dental Emergency is a situation where You have severe pain, swelling, or bleeding in or around Your mouth. If You have a Dental Emergency, You should contact Your Primary Dental Office. If You are unable

to contact Your Primary Dental office, You should contact the Customer Service number on the front of this Evidence of Coverage to arrange treatment for Your Dental Emergency or go to a conveniently located general dentist. A Dental Emergency does not require preauthorization. Ask the dental office to call the Customer Service Unit to verify coverage at the telephone number listed on the front of this Evidence of Coverage. Obtain an itemized bill from the dental office to submit to the address in the Introduction Section of this Evidence of Coverage. The Plan will cover certain diagnostic and therapeutic procedures in accordance with the Schedule of Benefits. Your out-of-pocket cost will be limited to any applicable Copayment on the Schedule of Benefits. Members must return to their Primary Dental Office for any necessary follow-up care.

## Member Reimbursement Provisions

In the event that a Primary Dental Office or Specialty Care Dentist is not available, the Company may authorize treatment by an Out-of-Network Dentist. The Member is liable for only the applicable Copayment, as indicated in the appropriate Schedule of Benefits for the Member. If the Member has paid the Out-of-Network Dentist, the Company will reimburse the Subscriber the difference between the charge and the Copayment as listed in the appropriate Schedule of Benefits. Members should submit a claim form to the address noted on the front of this Evidence of Coverage within 60 days of obtaining the authorization for treatment as described above or within 60 days for a Dental Emergency received from an Out-of-Network Dentist. Most treating dentists will provide and complete the claim form for You. However, if You need to obtain a claim form, You may do so on our website at www.unitedconcordia.com.

## Liability of Members in the Event of Non-payment

All contracts between the Company and the Primary Dentist or Specialty Care Dentist state that under no circumstances shall the Member be liable to any dentist for any sum owed by the Company to the dentist. In any instance where the Company fails or refuses to pay the dentist, such dispute is solely between the dentist and the Company, and the Member is not liable for any monies the Company fails or refuses to pay.

# BENEFITS

## Schedule of Benefits

Your benefits are detailed in the Schedule of Benefits attached to this Evidence of Coverage. Your Schedule of Benefits shows:

- the dental procedures covered under the Plan
- the Copayment for each procedure which You are responsible to pay Your Primary Dentist or Specialty Care Dentist

## Your Out-of-Pocket Costs

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 by Your Plan. 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 uncovered services.

Certain procedures listed on the Schedule of Benefits require a Copayment from You. 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 dental office. 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 the Schedule of Benefits attached to this Evidence of Coverage.

## Other Charges

You are responsible for charges as listed on the Schedule of Benefits. Services not listed on the Schedule of Benefits are not covered and are Your responsibility.

***IMPORTANT:*** *If You opt to receive dental services that are not Covered Services under this Plan, an In-Network Dentist may charge You his or her usual and customary rate for those services. Prior to providing a Member with dental services that are not a Covered Service, the dentist should provide to the Member a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about dental coverage options, You may call out Customer Service Department at 866-357-3304 or Your insurance broker. To fully understand Your coverage, You may wish to carefully review this Evidence of Coverage.*

## Dental Services

This section provides brief descriptions of the most common types of services provided by dentists. If a service is listed below does not mean it is a covered service under in Your specific Plan. This list is not all-inclusive. You must review Your Schedule of Benefits and Exclusions and Limitations to determine Your Covered Services.

Exams for diagnosis: inspection of the inside of the mouth by a dentist to identify any disease that needs treatment.

X-rays for diagnosis: the type and amount of x-rays taken for the dentist to identify any disease that needs treatment.

- Bitewing x-rays check-up x-rays of both the upper and lower teeth, usually isolated to the back teeth only, taken with the patient biting the teeth together.
- Panoramic or full mouth x-rays x-rays that scan both the bone and teeth of the entire upper and lower jaws to identify any disease that needs treatment.

Routine Prophylaxis: standard teeth cleaning and polishing.

Periodontal maintenance: "deep" cleaning done on check-up visits after treatment for gum disease.

Sealants: plastic coating placed on the biting areas of the back teeth to help prevent decay from forming.

Fluoride treatment: a highly concentrated chemical placed on the teeth to make them resistant to decay.

Palliative Treatment: procedures to relieve pain.

Space Maintainers: metal and/or acrylic devices used to prevent tooth movement.

Basic Restorative: procedures used to treat caries (cavities, tooth decay) – e.g. amalgam(s), resin fillings, stainless steel crowns, crown build-ups and posts and cores.

Endodontics: treats the dental pulp, pulp chamber and root canal – root canal treatment and retreatment, pulpotomy, pulpal therapy, apicoectomy, and apexification.

- Pulpal therapy: a type of root canal done on primary teeth.

Non-surgical Periodontics: for non-surgical treatment of diseases of the gums and bones supporting the teeth – periodontal scaling and root planing, periodontal maintenance

Periodontal scaling and root planning: a "deep cleaning" to remove tartar from the roots of the teeth, usually done in multiple appointments and with local anesthesia.

Simple Extractions: non-surgical removal of teeth and roots

Surgical Periodontics: surgery done to treat gum disease.

- Gingivectomy: removal of excess gum tissue
- Osseous surgery: gum surgery to treat gum disease and bone loss

Inlays, Onlays, Crowns:

- Inlay: a dental filling that is made from an impression of the tooth, in a laboratory and cemented into the tooth.
- Onlay: a type of conservative crown that covers the biting surface of the tooth but only partially covers the sides of the tooth.
- Crown: a cap that usually covers the entire exterior surface of the tooth.

Prosthetics:

- Fixed bridges: an appliance that replaces one or more missing tooth by being cemented or bonded onto anchoring teeth that are next to the missing tooth/teeth.

- Partial denture: a removable appliance that replaces missing teeth and anchors onto the remaining teeth in either the upper or lower jaw.
- Complete dentures: a removable appliance that replaces all the teeth in either the upper or lower jaw.

Orthodontics:

- for treatment of poor alignment and occlusion – diagnostic x-rays, active treatment and retention for eligible dependent children.

## Exclusions

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.

## Alternative Treatment

All diagnosis and treatment planning is provided by Your Primary Dental Office. Occasionally, You and Your Primary Dental Office may consider possible alternative treatment plans. In those instances, where You agree to an alternative treatment plan as opposed to the Covered Service, 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.

The Primary Dental Office should discuss and provide the costs and receive Your authorization for the alternative treatment, in writing, before the services are performed.

## Payment of Benefits

We will pay for covered benefits directly to Your assigned Primary Dental Office or the Specialty Care Dentist. Payment with In-Network Dentists is based on contracted allowances.

All contracts between the Company and the In-Network Dentist states that under no circumstances will the Member be liable for any sum owed by the Company to the dentist. In any instance where the Company fails or refuses to pay the dentist, such dispute is solely between the dentist and the Company. The Member is not liable for any monies the Company fails or refuses to pay.

The Company maintains claim and eligibility records required by federal and state law. The Company maintains physical, electronic, and procedural safeguards to guard claims and eligibility information from unauthorized access, use, and disclosure.

## 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 the Primary Dental Benefit Plan and determine its benefits before those of the other plan and without considering the other plan's benefits. The other plan will be the Secondary Dental Benefit Plan and determine its benefits after the Primary Dental Benefit Plan. The Secondary Dental Benefit Plan's benefits may be reduced because of the Primary Dental Benefit Plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses to prevent duplicate payments and overpayments. Upon determination of primary or secondary liability, This Plan will determine payment. If This Plan is the Secondary Dental Benefit Plan, payment during the Claim Determination Period will not exceed the total of the Allowable amount.

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. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service provided shall be deemed to be both an Allowable Amount and a benefit paid.

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: Medicare, 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 Dental Benefit Plan** is the plan which provides primary dental coverage and 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 Dental Benefit Plan** is the plan which provides secondary dental coverage and determines its benefits after those of the other plan (Primary Dental Benefit Plan). Benefits may be reduced because of the other plan's (Primary Dental Benefit Plan) benefits.

F) **This 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.

G) **Plan** means either the Primary Dental Benefit Plan or the Secondary Dental Benefit Plan.

2. The reasonable cash 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.

   A) As the Primary Dental Benefit Plan, the Company will pay the maximum amount required by Your Group Policy when coordinating its benefits with a Secondary Dental Benefit Plan.

   B) As the Secondary Dental Benefit Plan, the Company will pay the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the Member's total out-of-pocket cost payable under the Primary Dental Benefit Plan for benefits covered under the Secondary Dental Benefit Plan.

3. In order to determine which Plan is primary, This Plan will use the following rules:

   A) If the Other Dental Plan does not have a provision similar to this one, then that Plan will be primary and This Plan's Coordination of Benefits rules apply.

   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 or other rule, and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent or other rule 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. A retirement Plan refers to a Plan covering a retired employee or Dependent of an employee. An active Plan refers to a Plan that covers a person as an employee or Dependent of an employee. When two retirement Plans are involved, the one in effect for the longest time is primary. When Plan is under a retirement Plan and the other Plan is for a laid off employee, the Plan of the laid off employee is primary. If another contract does not have this rule which results in each Plan determine benefits of another, then this rule will be ignored.

F) The Plan covering an individual as a Cal-COBRA continuee will be secondary to a Plan covering that individual as a Subscriber, or a Member. If another Plan does not have this rule which results in each Plan determine benefits of another, then this rule will be ignored.

G) If none of these rules apply, then the contract which has continuously covered the Member for whom the claim was made for a longer period of time will be primary.

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 benefits provided in the form of 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 the administration of Your Plan's benefit, please contact Our Customer Service Department at the toll-free telephone number in the Introduction section of this Evidence of Coverage. If, after speaking with a Customer Service representative, You are still dissatisfied, refer to the following Second Opinion and Dispute Resolution Procedure for further steps You can take regarding Your claim.

## Second Opinion

You or Your In-Network Dentist may request a second opinion. The request for second opinion may be made by calling or writing Dental Customer Service at the address or telephone number shown below under "Grievance Resolution". Reasons for a second opinion include, but are not limited to:

1. If the Member has questions on the reasonableness or necessity of recommended surgical procedures;
2. If the Member has questions on a diagnosis or plan of care for a condition that threatens life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition;
3. If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the Member requests an additional diagnosis;
4. If the treatment plan in progress is not improving the dental condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment; or
5. If the Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

Authorization or denial of a second opinion request will be made in an expeditious manner. When a Member's condition is such that the Member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness that would be detrimental to the Member's ability to regain maximum function, the decision for authorization or denial for second opinion will be rendered in a timely fashion appropriate for the nature of the condition, not to exceed 72 hours from the receipt of the request, whenever possible. These written guidelines regarding timelines for responding to second opinion requests are available to Plan Members upon request.

The cost of an authorized second opinion will be the responsibility of the Plan, minus any applicable patient Copayment to be paid by the Member at the time of service. Non-authorized second opinions are the sole financial responsibility of the Member.

An authorized second opinion will be provided by an appropriately qualified contracted provider of the Member's choice. If no other Plan provider is reasonably available who meets this standard, then the Plan will authorize an out-of-network second opinion. Second opinions are not covered with out-of-network providers without prior approval of the Plan.

If a request for second opinion is denied by the Plan, the Member may file a grievance following the Grievance Resolution Procedure.

## GRIEVANCE RESOLUTION PROCEDURE

Any Member not satisfied with any aspect of United Concordia may file a written complaint/grievance. While United Concordia prefers the complaint/grievance to be filed by the Member in writing due to the more concise nature of written statements as compared to verbal statements, complaints/grievances may be submitted verbally with the assistance of a United Concordia representative. Assistance with filing a complaint/grievance is provided, as necessary, at each location where complaints/grievances may be filed. The Member, or a person acting on the Member's behalf, must file a complaint/grievance within 180 days following the incident(s) or action(s) that is(are) the subject(s) of the enrollee's dissatisfaction. The complaint/grievance should contain sufficient detail to identify the nature of the problem.

A letter or completed United Concordia Dissatisfaction Report must be submitted to the Customer Services Department at: P.O. Box 10194, Van Nuys, CA 91410-0194, or via United Concordia's website www.unitedconcordia.com, or You may call Customer Service at 866-357-3304 for assistance.

A Member who files a complaint/grievance will not be subject to discrimination, disenrollment, or otherwise penalized for filing a grievance.

Complaint/Grievance forms and a description of the complaint/grievance procedure are available directly from United Concordia, on United Concordia's website www.unitedconcordia.com and at each contracted provider's facility, and are provided promptly upon request.

Receipt of Your concern will be acknowledged within five (5) days. After receipt, all parties involved will be contacted and any pertinent facts, dental records, or other supportive materials will be collected. **A copy of Your grievance will be forwarded to the dental office(s) which is/are the subject of the grievance.**

Complaints/grievances will be resolved within 30 days. A notice of the disposition for the complaint/grievance will be sent to the Member within 30 days from the receipt of the complaint/grievance.

A Member may file a complaint/grievance with the Department of Managed Health Care (DMHC) if no response is received from United Concordia within 30 days or as soon as a written decision has been rendered, or any time in any case determined by the DMHC to be a case involving imminent and serious threat to the health of the patient, including but not limited to severe pain, potential loss of life, limb, or major bodily function, or in any case where the DMHC determines that an earlier review is warranted.

Because of regulations concerning the confidentiality of patient medical records, any resolution to complaint/grievance will be forwarded to the Dental Office and Member only. All such replies will be made in writing and will be held in the strictest confidence.

For Members who are not proficient in English, who are hearing impaired, who are visually impaired, or who are otherwise impaired such that access to United Concordia's complaint/grievance system is potentially hampered, United Concordia provides assistance as necessary.

United Concordia's complaint/grievance system addresses the linguistic and cultural needs of its Members as well as the needs of Members with disabilities, to ensure that all Members have access to and can fully participate in the complaint/grievance system, by the following means:

1. Translations of complaint/grievance procedures, forms, and Plan responses to complaints/grievances, as needed,
2. Access to telephone interpreters,
3. Access to telephone relay systems and other devices that aid disabled individuals to communicate,
4. Other individualized assistance to meet the Member's specific needs.

You can access the above referenced services by contacting Customer Service at 866-357-3304.

In the event that an expedited complaint/grievance is filed that involves an imminent or serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, United Concordia will conduct an expedited review of the complaint/grievance. Upon United Concordia's notice of an expedited review case, United Concordia will immediately inform the Member of his/her right and method to notify the DMHC of the complaint/grievance. United Concordia also will notify the Member of the disposition or pending status of the expedited complaint/grievance no later than three (3) days from receipt of the complaint/grievance.

Due to regulatory constraints on the timeline for complaint/grievance resolution, a complaint/grievance determination **may not** be appealed to United Concordia.

**"The California Department of Managed Health Care is responsible for regulating health care service plans. If You have a grievance against Your health plan, You should first telephone Your health Plan at 866-357-3304 and use Your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If You need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Your health plan, or a grievance that has remained unresolved for more than 30 days, You may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If You are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are**

**experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."**

## RENEWAL PROVISIONS

Upon completion of the original term, this Evidence of Coverage shall automatically be renewed on an annual basis as provided for in the Group Contract. The Company will supply You with a copy of the Group Contract upon request.

## RIGHT OF CANCELLATION AND RESTRICTIONS ON RENEWAL

This Plan may also be cancelled or terminated at any time based upon the Termination of Benefits Section below.

## TERMINATION OF BENEFITS

Your coverage and/or Your Dependents' coverage will end at 12:01 AM PST:

- on the date You lose eligibility under Your Group's eligibility requirements; or
- on the date Premium payment ceases for You and/or Your Dependents, as specified by Your Group; or
- on the date Your Dependent(s) cease to meet the requirements in the definition of Dependent in the Definitions section of this Evidence of Coverage; or
- on the postmark date We provide notice to You of a final disposition of a fraud conviction by You or Your Dependents; or
- on the date of a change of the Subscriber's residence to an area outside the State of California. Coverage shall continue for Dependents who reside in California with a non-custodial parent.

If Your coverage or Your Dependents' coverage is terminated as described above, coverage for completion of a dental procedure requiring two or more visits on separate days will be extended for a period of 90 days after the Member's Termination Date in order for the procedure to be finished. The procedure must be started prior to the Member's Termination Date. The procedure is considered "started" when the procedure cannot be undone or reversed. 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 Member's Termination Date.

The Company is not liable to pay any benefits for services, which are performed after the Termination Date of a Member's coverage or of the Group Contract.

Coverage shall remain in effect for 31 days after the due date of the Premium. If the Premium is not received within the Grace Period, coverage will be immediately cancelled on the first day following the expiration of the Grace Period. The Contractholder is liable for Premium accrued during the Grace Period.

A Member who alleges that this Evidence of Coverage was not renewed or terminated due to a family Member's or Subscriber's health status may request a review for cancellation from the Director of the Department of Managed Health Care.

## FEDERAL COBRA

Federal law may require certain employers to offer continuation coverage to Members for a specified period of time upon termination of employment or reduction of work hours for any reason other than gross misconduct. You should contact Your employer to find out whether or not this requirement applies to You and Your employer. Your employer will advise You of Your rights to continuation coverage and the cost. If this requirement does apply, You must elect to continue coverage within 60 days from Your qualifying event or notification of rights by Your employer, whichever is later. You may elect to extend Dependent(s')

coverage, or the Dependent(s) may elect to continue coverage under certain circumstances or qualifying events. Dependent(s) must elect to continue coverage within 60 days from the event or notification of rights by Your employer, whichever is later. You must pay the required premium for continuation coverage directly to Your employer. The Company is not responsible for determining who is eligible for continuation coverage.

## GENERAL PROVISIONS

This Evidence of Coverage 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 subject matter. The failure of any section or subsection of this Evidence of Coverage shall not affect the validity, legality and enforceability of the remaining sections.

The Company may assign this Evidence of Coverage, with the approval of the Department of Managed Health Care (or its successors) and its rights and obligations hereunder to any entity under common control with the Company.

This Evidence of Coverage will be construed for all purposes as a legal document and will be interpreted and enforced in accordance with pertinent laws and regulations of the State of California.

### Confidentiality of Dental Records

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

### Rights of Company to Change Plan

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

### Suggestions and Comments

The Company welcomes suggestions and comments to improve the service for this Plan. Members may submit questions and comments to the Company's Public Policy Committee. The Public Policy Committee establishes and reviews the Plan's public policy. The Committee consists of representatives of at least 51% of Covered Members under this Plan. If You wish to be considered for selection to the Committee, submit Your qualifications in writing to the address on the front of this Evidence of Coverage. The Plan reviews its Committee membership annually. The Plan will notify You of its selection decisions after that annual review.

**NEW MEMBER CONTINUATION OF CARE INFORMATION**

Continuation of Care:

If You have been receiving care from a dental care provider, You may have a right to keep Your dental care provider for a designated time period. Please contact this Plan's customer service department at 1-866-357-3304, and if You have further questions, You are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov. You may also obtain a copy of our policy on continuation of care from our customer service department. This policy does not apply to a newly covered enrollee covered under an individual subscriber agreement.

You must make a specific request to continue under the care of Your current provider. We are not required to continue Your care with that provider if You are not eligible under our policy or if we cannot reach agreement with your provider on the terms regarding Your care in accordance with California law.

**FEDERAL LAW SUPPLEMENT**

**TO**

**CERTIFICATE OF INSURANCE**

This Supplement amends your Certificate by adding the following provisions regarding special enrollment periods and extended coverage requirements currently mandated or that may be mandated in the future under federal law.

You may enroll for dental coverage at any time for yourself and your dependents if:

(1) You or your dependent either loses eligibility for coverage under Medicaid or the Children's Health Insurance Program ("CHIP"); or

(2) You or your dependent becomes eligible for premium assistance from Medicaid or CHIP allowing enrollment in a benefit program.

In order to enroll, you must submit complete enrollment information to your group or its plan administrator within sixty (60) days from your or your dependent's loss of coverage or eligibility for premium assistance, as the case may be.

Other special enrollment periods and rights may apply to you or your dependents under new or existing federal laws. Consult your group, its plan administrator or your group's summary plan description for information about any new or additional special enrollment periods, enrollment rights or extended coverage periods for dependents mandated under federal law.

**UNITED CONCORDIA DENTAL PLANS OF CALIFORNIA, INC.**

**RIDER**

**TO**

**GROUP CONTRACT**
**AND**
**COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM**
**("EVIDENCE OF COVERAGE")**

This Rider is effective on the Effective Date stated in the Group Contract and is attached to and made a part of the Group Contract and Evidence of Coverage.

Dependents as defined in the above-referenced Evidence of Coverage are not eligible for enrollment under the Group Contract.

All references to and provisions relating to such Dependents in the Group Contract, Evidence of Coverage and all riders, schedules and applications incorporated therein by reference are not applicable to this Plan.

# UNITED CONCORDIA

**Concordia Plus**
**Schedule of Benefits**
**Plan CA 946**

## IMPORTANT INFORMATION ABOUT YOUR PLAN

- This Schedule of Benefits provides a listing of procedures covered by Your Plan. For procedures that require a Copayment, the amount to be paid is shown in the column titled "Member Pays $." You pay these Copayments to the dental office at the time of service.
- You must select a United Concordia Primary Dental Office (PDO) to receive Covered Services. Your PDO will perform the below procedures or refer You to a Specialty Care Dentist for further care. Treatment by an Out of Network Dentist is not covered, except as described in the Evidence of Coverage.
- Only procedures listed on this Schedule of Benefits are Covered Services. For services not listed (not covered), You are responsible for the full fee charged by the dentist. Procedure codes and member Copayments may be updated to meet American Dental Association (ADA) Current Dental Terminology (CDT) in accordance with national standards.
- In-Network Dentists will charge an additional $125 for the use of precious (high noble) or semi precious (noble) metal.
- For a complete description of Your Plan, please refer to the Evidence of Coverage and the Exclusions and Limitations in addition to this Schedule of Benefits.
- If You have any questions about Your United Concordia Dental Plan, please call Our Customer Service Department toll free at **1-866-357-3304** or access Our Website at **www.unitedconcordia.com**.

| ADA CODE | ADA DESCRIPTION | Member Pays $ |
|---|---|---|
| | **CLINICAL ORAL EVALUATIONS** | |
| D0120 | Periodic oral evaluation - established patient | 0 |
| D0140 | Limited oral evaluation - problem focused | 0 |
| D0145 | Oral evaluation for a patient under three years of age and counseling with primary caregiver | 0 |
| D0150 | Comprehensive oral evaluation - new or established patient | 0 |
| D0160 | Detailed and extensive oral evaluation - problem focused, by report | 0 |
| D0170 | Re-evaluation - limited, problem focused (established patient; not post-operative visit) | 0 |
| D0180 | Comprehensive periodontal evaluation - new or established patient | 0 |
| | **RADIOGRAPHS/DIAGNOSTIC IMAGING** | |
| | **(including interpretation)** | |
| D0210 | Intraoral - complete series (including bitewings) | 0 |
| D0220 | Intraoral - periapical first film | 0 |
| D0230 | Intraoral - periapical each additional film | 0 |
| D0240 | Intraoral - occlusal film | 0 |
| D0250 | Extraoral - first film | 0 |
| D0260 | Extraoral - each additional film | 0 |
| D0270 | Bitewing - single film | 0 |
| D0272 | Bitewings - two films | 0 |
| D0273 | Bitewings - three films | 0 |
| D0274 | Bitewings - four films | 0 |
| D0277 | Vertical bitewings - 7 to 8 films | 0 |
| D0330 | Panoramic film | 0 |
| D0340 | Cephalometric film | 0 |
| D0350 | Oral/facial photographic images | 15 |
| | **TESTS AND EXAMINATIONS** | |
| D0415 | Collection of microorganisms for culture and sensitivity | 0 |
| D0416 | Viral culture | 0 |
| D0417 | Collection and preparation of saliva sample for laboratory diagnostic testing | 30 |
| D0418 | Analysis of saliva sample | 25 |
| D0421 | Genetic test for susceptibility to oral disease | 0 |
| D0425 | Caries susceptibility tests | 0 |
| D0431 | Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures | 0 |
| D0460 | Pulp vitality tests | 0 |
| D0470 | Diagnostic casts | 0 |
| | **ORAL PATHOLOGY LABORATORY** | |
| D0472 | Accession of tissue, gross examination, preparation and transmission of written report | 35 |
| D0473 | Accession of tissue, gross and microscopic examination, preparation and transmission of written report | 55 |
| D0474 | Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmision of written report | 75 |
| D0502 | Other oral pathology procedures, by report | 55 |
| | **DENTAL PROPHYLAXIS** | |
| D1110 | Prophylaxis - adult | 0 |
| D1120 | Prophylaxis - child | 0 |
| | **TOPICAL FLUORIDE TREATMENT** | |
| | **(office procedure)** | |
| D1203 | Topical application of fluoride - child | 0 |
| D1204 | Topical application of fluoride - adult | 0 |
| D1206 | Topical fluoride varnish; therapeutic application for moderate to high risk patients | 0 |
| | **OTHER PREVENTIVE SERVICES** | |
| D1310 | Nutritional counseling for control of dental disease | 0 |
| D1320 | Tobacco counseling for the control and prevention of oral disease | 0 |
| D1330 | Oral hygiene instructions | 0 |
| D1351 | Sealant - per tooth | 0 |
| | **SPACE MAINTENANCE** | |
| | **(passive appliances)** | |
| D1510 | Space maintainer - fixed - unilateral | 55 |
| D1515 | Space maintainer - fixed - bilateral | 84 |
| D1520 | Space maintainer - removable - unilateral | 66 |
| D1525 | Space maintainer - removable - bilateral | 85 |
| D1550 | Re-cementation of space maintainer | 0 |
| D1555 | Removal of fixed space maintainer | 8 |
| | **AMALGAM RESTORATIONS** | |
| | **(including polishing)** | |
| D2140 | Amalgam - one surface, primary or permanent | 14 |
| D2150 | Amalgam - two surfaces, primary or permanent | 15 |
| D2160 | Amalgam - three surfaces, primary or permanent | 16 |

| ADA CODE | ADA DESCRIPTION | Member Pays $ |
|---|---|---|
| D2161 | Amalgam - four or more surfaces, primary or permanent | 20 |
| | **RESIN-BASED COMPOSITE RESTORATIONS - DIRECT** | |
| D2330 | Resin-based composite - one surface, anterior | 19 |
| D2331 | Resin-based composite - two surfaces, anterior | 21 |
| D2332 | Resin-based composite - three surfaces, anterior | 25 |
| D2335 | Resin-based composite - four or more surfaces or involving incisal angle (anterior) | 31 |
| D2390 | Resin-based composite crown, anterior | 31 |
| D2391 | Resin-based composite - one surface, posterior | 85 |
| D2392 | Resin-based composite - two surfaces, posterior | 109 |
| D2393 | Resin-based composite - three surfaces, posterior | 133 |
| D2394 | Resin-based composite - four or more surfaces, posterior | 140 |
| | **INLAY/ONLAY RESTORATIONS** | |
| D2510 | Inlay - metallic - one surface | 62◆ |
| D2520 | Inlay - metallic - two surfaces | 185◆ |
| D2530 | Inlay - metallic - three or more surfaces | 190◆ |
| D2542 | Onlay - metallic - two surfaces | 174◆ |
| D2543 | Onlay - metallic - three surfaces | 195◆ |
| D2544 | Onlay - metallic - four or more surfaces | 195◆ |
| | **CROWNS - SINGLE RESTORATIONS ONLY** | |
| D2710 | Crown - resin-based composite (indirect) | 69 |
| D2712 | Crown - 3/4 resin-based composite (indirect) | 69 |
| D2720 | Crown - resin with high noble metal | 237◆ |
| D2721 | Crown - resin with predominantly base metal | 210 |
| D2722 | Crown - resin with noble metal | 221◆ |
| D2740 | Crown - porcelain/ceramic substrate | 237 |
| D2750 | Crown - porcelain fused to high noble metal | 237◆ |
| D2751 | Crown - porcelain fused to predominantly base metal | 210 |
| D2752 | Crown - porcelain fused to noble metal | 221◆ |
| D2780 | Crown - 3/4 cast high noble metal | 224◆ |
| D2781 | Crown - 3/4 cast predominantly base metal | 197 |
| D2782 | Crown - 3/4 cast noble metal | 214◆ |
| D2783 | Crown - 3/4 porcelain/ceramic | 237 |
| D2790 | Crown - full cast high noble metal | 224◆ |
| D2791 | Crown - full cast predominantly base metal | 210 |
| D2792 | Crown - full cast noble metal | 214◆ |
| D2794 | Crown - titanium | 210 |
| D2799 | Provisional crown | 0 |
| | **OTHER RESTORATIVE SERVICES** | |
| D2910 | Recement inlay, onlay, or partial coverage restoration | 21 |
| D2915 | Recement cast or prefabricated post and core | 21 |
| D2920 | Recement crown | 21 |
| D2930 | Prefabricated stainless steel crown - primary tooth | 53 |
| D2931 | Prefabricated stainless steel crown - permanent tooth | 57 |
| D2932 | Prefabricated resin crown | 55 |
| D2933 | Prefabricated stainless steel crown with resin window | 75 |
| D2934 | Prefabricated esthetic coated stainless steel crown - primary tooth | 75 |
| D2940 | Sedative filling | 0 |
| D2950 | Core buildup, including any pins | 15 |
| D2951 | Pin retention - per tooth, in addition to restoration | 4 |
| D2952 | Post and core in addition to crown, indirectly fabricated | 85 |
| D2953 | Each additional indirectly fabricated post - same tooth | 10 |
| D2954 | Prefabricated post and core in addition to crown | 70 |
| D2955 | Post removal (not in conjunction with endodontic therapy) | 0 |
| D2957 | Each additional prefabricated post - same tooth | 10 |
| D2970 | Temporary crown (fractured tooth) | 53 |
| D2971 | Additional procedures to construct new crown under existing partial denture framework | 25 |
| D2980 | Crown repair, by report | 25 |
| | **PULP CAPPING** | |
| D3110 | Pulp cap - direct (excluding final restoration) | 0 |
| D3120 | Pulp cap - indirect (excluding final restoration) | 0 |
| | **PULPOTOMY** | |
| D3220 | Therapeutic pulpotomy (excluding final restoration) | 25 |
| D3221 | Pulpal debridement, primary and permanent teeth | 25 |
| D3222 | Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development | 25 |
| | **ENDODONTIC THERAPY ON PRIMARY TEETH** | |
| D3230 | Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) | 30 |
| D3240 | Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | 33 |
| | **ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)** | |
| D3310 | Endodontic therapy, anterior tooth (excluding final restoration) | 60 |
| D3320 | Endodontic therapy, bicuspid tooth (excluding final restoration) | 75 |
| D3330 | Endodontic therapy, molar (excluding final restoration) | 175 |
| | **ENDODONTIC RETREATMENT** | |
| D3346 | Retreatment of previous root canal therapy - anterior | 85 |
| D3347 | Retreatment of previous root canal therapy - bicuspid | 95 |
| D3348 | Retreatment of previous root canal therapy - molar | 125 |
| | **APEXIFICATION/RECALCIFICATION PROCEDURES** | |
| D3351 | Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) | 150 |
| D3352 | Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) | 95 |
| D3353 | Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) | 120 |
| | **APICOECTOMY/PERIRADICULAR SERVICES** | |
| D3410 | Apicoectomy/periradicular surgery - anterior | 90 |
| D3421 | Apicoectomy/periradicular surgery - bicuspid (first root) | 90 |
| D3425 | Apicoectomy/periradicular surgery - molar (first root) | 90 |
| D3426 | Apicoectomy/periradicular surgery (each additional root) | 40 |
| D3430 | Retrograde filling - per root | 0 |
| D3450 | Root amputation - per root | 0 |

| ADA CODE | ADA DESCRIPTION | Member Pays $ |
|---|---|---|
| | **OTHER ENDODONTIC PROCEDURES** | |
| D3910 | Surgical procedure for isolation of tooth with rubber dam | 0 |
| D3920 | Hemisection (including any root removal), not including root canal therapy | 55 |
| D3950 | Canal preparation and fitting of preformed dowel or post | 0 |
| | **SURGICAL SERVICES** | |
| | **(including usual postoperative care)** | |
| D4210 | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | 65 |
| D4211 | Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | 30 |
| D4240 | Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant | 55 |
| D4241 | Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant | 22 |
| D4245 | Apically positioned flap | 70 |
| D4249 | Clinical crown lengthening - hard tissue | 75 |
| D4260 | Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant | 100 |
| D4261 | Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant | 40 |
| D4263 | Bone replacement graft - first site in quadrant | 120 |
| D4264 | Bone replacement graft - each additional site in quadrant | 92 |
| D4274 | Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) | 50 |
| | **NON-SURGICAL PERIODONTAL SERVICES** | |
| D4341 | Periodontal scaling and root planing - four or more teeth per quadrant | 35 |
| D4342 | Periodontal scaling and root planing - one to three teeth per quadrant | 9 |
| D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis | 35 |
| D4381 | Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, per report | 43 |
| | **OTHER PERIODONTAL SERVICES** | |
| D4910 | Periodontal maintenance | 40 |
| D4920 | Unscheduled dressing change (by someone other than treating dentist) | 30 |
| | **COMPLETE DENTURES** | |
| | **(including routine post-delivery care)** | |
| D5110 | Complete denture - maxillary | 294 |
| D5120 | Complete denture - mandibular | 294 |
| D5130 | Immediate denture - maxillary | 307 |
| D5140 | Immediate denture - mandibular | 307 |
| | **PARTIAL DENTURES** | |
| | **(including routine post-delivery care)** | |
| D5211 | Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) | 250 |
| D5212 | Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) | 250 |
| D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 345 |
| D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 345 |
| D5225 | Maxillary partial denture - flexible base (including any clasps, rests and teeth) | 397 |
| D5226 | Mandibular partial denture - flexible base (including any clasps, rests and teeth) | 397 |
| D5281 | Removable unilateral partial denture - one piece cast metal (including clasps and teeth) | 148 |
| | **ADJUSTMENTS TO DENTURES** | |
| D5410 | Adjust complete denture - maxillary | 13 |
| D5411 | Adjust complete denture - mandibular | 18 |
| D5421 | Adjust partial denture - maxillary | 18 |
| D5422 | Adjust partial denture - mandibular | 18 |
| | **REPAIRS TO COMPLETE DENTURES** | |
| D5510 | Repair broken complete denture base | 35 |
| D5520 | Replace missing or broken teeth - complete denture (each tooth) | 29 |
| | **REPAIRS TO PARTIAL DENTURES** | |
| D5610 | Repair resin denture base | 34 |
| D5620 | Repair cast framework | 35 |
| D5630 | Repair or replace broken clasp | 35 |
| D5640 | Replace broken teeth - per tooth | 32 |
| D5650 | Add tooth to existing partial denture | 37 |
| D5660 | Add clasp to existing partial denture | 44 |
| D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | 225 |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | 225 |
| | **DENTURE REBASE PROCEDURES** | |
| D5710 | Rebase complete maxillary denture | 97 |
| D5711 | Rebase complete mandibular denture | 105 |
| D5720 | Rebase maxillary partial denture | 52 |
| D5721 | Rebase mandibular partial denture | 67 |
| | **DENTURE RELINE PROCEDURES** | |
| D5730 | Reline complete maxillary denture (chairside) | 70 |
| D5731 | Reline complete mandibular denture (chairside) | 70 |
| D5740 | Reline maxillary partial denture (chairside) | 53 |
| D5741 | Reline mandibular partial denture (chairside) | 56 |
| D5750 | Reline complete maxillary denture (laboratory) | 75 |
| D5751 | Reline complete mandibular denture (laboratory) | 75 |
| D5760 | Reline maxillary partial denture (laboratory) | 65 |
| D5761 | Reline mandibular partial denture (laboratory) | 65 |
| D5810 | Interim complete denture - maxillary | 307 |
| D5811 | Interim complete denture - mandibular | 307 |
| D5820 | Interim partial denture - maxillary | 125 |
| D5821 | Interim partial denture - mandibular | 125 |
| | **OTHER REMOVABLE PROSTHETIC SERVICES** | |
| D5850 | Tissue conditioning, maxillary | 30 |
| D5851 | Tissue conditioning, mandibular | 30 |
| | **FIXED PARTIAL DENTURE PONTICS** | |
| D6205 | Pontic - indirect resin based composite | 201 |
| D6210 | Pontic - cast high noble metal | 210◆ |
| D6211 | Pontic - cast predominantly base metal | 200 |
| D6212 | Pontic - cast noble metal | 210◆ |
| D6214 | Pontic - titanium | 200 |
| D6240 | Pontic - porcelain fused to high noble metal | 225◆ |

| ADA CODE | ADA DESCRIPTION | Member Pays $ |
|---|---|---|
| D6241 | Pontic - porcelain fused to predominantly base metal | 210 |
| D6242 | Pontic - porcelain fused to noble metal | 225◆ |
| D6245 | Pontic - porcelain/ceramic | 201 |
| D6250 | Pontic - resin with high noble metal | 225◆ |
| D6251 | Pontic - resin with predominantly base metal | 210 |
| D6252 | Pontic - resin with noble metal | 225◆ |
| | **FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS** | |
| D6545 | Retainer - cast metal for resin bonded fixed prosthesis | 138 |
| D6548 | Retainer - porcelain/ceramic for resin bonded fixed prosthesis | 207 |
| D6602 | Inlay - cast high noble metal, two surfaces | 185◆ |
| D6603 | Inlay - cast high noble metal, three or more surfaces | 190◆ |
| D6604 | Inlay - cast predominantly base metal, two surfaces | 185 |
| D6605 | Inlay - cast predominantly base metal, three or more surfaces | 190 |
| D6606 | Inlay - cast noble metal, two surfaces | 185◆ |
| D6607 | Inlay - cast noble metal, three or more surfaces | 190◆ |
| D6610 | Onlay - cast high noble metal, two surfaces | 174◆ |
| D6611 | Onlay - cast high noble metal, three or more surfaces | 195◆ |
| D6612 | Onlay - cast predominantly base metal, two surfaces | 174 |
| D6613 | Onlay - cast predominantly base metal, three or more surfaces | 195 |
| D6614 | Onlay - cast noble metal, two surfaces | 174◆ |
| D6615 | Onlay - cast noble metal, three or more surfaces | 195◆ |
| D6624 | Inlay - titanium | 190 |
| D6634 | Onlay - titanium | 195 |
| | **FIXED PARTIAL DENTURE RETAINERS - CROWNS** | |
| D6710 | Crown - indirect resin based composite | 237 |
| D6720 | Crown - resin with high noble metal | 237◆ |
| D6721 | Crown - resin with predominantly base metal | 210 |
| D6722 | Crown - resin with noble metal | 221◆ |
| D6740 | Crown - porcelain/ceramic | 237 |
| D6750 | Crown - porcelain fused to high noble metal | 237◆ |
| D6751 | Crown - porcelain fused to predominantly base metal | 214 |
| D6752 | Crown - porcelain fused to noble metal | 223◆ |
| D6780 | Crown - 3/4 cast high noble metal | 210◆ |
| D6781 | Crown - 3/4 cast predominantly base metal | 210 |
| D6782 | Crown - 3/4 cast noble metal | 210◆ |
| D6783 | Crown - 3/4 porcelain/ceramic | 237 |
| D6790 | Crown - full cast high noble metal | 219◆ |
| D6791 | Crown - full cast predominantly base metal | 210 |
| D6792 | Crown - full cast noble metal | 210◆ |
| D6794 | Crown - titanium | 210 |
| | **OTHER FIXED PARTIAL DENTURE SERVICES** | |
| D6930 | Recement fixed partial denture | 32 |
| D6940 | Stress breaker | 130 |
| D6950 | Precision attachment | 222 |
| D6970 | Post and core in addition to fixed partial denture retainer, indirectly fabricated | 70 |
| D6972 | Prefabricated post and core in addition to fixed partial denture retainer | 60 |
| D6973 | Core build up for retainer, including any pins | 46 |
| D6976 | Each additional indirectly fabricated post - same tooth | 10 |
| D6977 | Each additional prefabricated post - same tooth | 10 |
| D6980 | Fixed partial denture repair, by report | 25 |
| | **EXTRACTIONS** | |
| | **(includes local anesthesia, suturing, if needed, and routine postoperative care)** | |
| D7111 | Extraction, coronal remnants - deciduous tooth | 6 |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | 15 |
| | **SURGICAL EXTRACTIONS** | |
| | **(includes local anesthesia, suturing, if needed, and routine postoperative care)** | |
| D7210 | Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth | 35 |
| D7220 | Removal of impacted tooth - soft tissue | 40 |
| D7230 | Removal of impacted tooth - partially bony | 45 |
| D7240 | Removal of impacted tooth - completely bony | 50 |
| D7241 | Removal of impacted tooth - completely bony, with unusual surgical complications | 55 |
| D7250 | Surgical removal of residual tooth roots (cutting procedure) | 30 |
| | **OTHER SURGICAL PROCEDURES** | |
| D7280 | Surgical access of an unerupted tooth | 32 |
| D7283 | Placement of device to facilitate eruption of impacted tooth | 8 |
| D7285 | Biopsy of oral tissue - hard (bone, tooth) | 78 |
| D7286 | Biopsy of oral tissue - soft | 90 |
| D7288 | Brush biopsy - transepithelial sample collection | 45 |
| | **ALVEOLOPLASTY** | |
| | **(surgical preparation of ridge for dentures)** | |
| D7310 | Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | 25 |
| D7311 | Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | 15 |
| D7320 | Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | 35 |
| D7321 | Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | 14 |
| | **SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS** | |
| D7450 | Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm | 55 |
| D7451 | Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm | 250 |
| | **EXCISION OF BONE TISSUE** | |
| D7471 | Removal of lateral exostosis (maxilla or mandible) | 250 |
| D7472 | Removal of torus palatinus | 250 |
| D7473 | Removal of torus mandibularis | 250 |
| D7485 | Surgical reduction of osseous tuberosity | 385 |
| | **SURGICAL INCISION** | |
| D7510 | Incision and drainage of abscess - intraoral soft tissue | 50 |
| D7511 | Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces) | 95 |
| D7520 | Incision and drainage of abscess - extraoral soft tissue | 75 |

| ADA CODE | ADA DESCRIPTION | Member Pays $ |
|---|---|---|
| D7521 | Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces) | 115 |
| | **REPAIR OF TRAUMATIC WOUNDS** | |
| D7910 | Suture of recent small wounds up to 5 cm | 100 |
| | **OTHER REPAIR PROCEDURES** | |
| D7960 | Frenulectomy (frenectomy or frenotomy) - separate procedure | 23 |
| D7963 | Frenuloplasty | 12 |
| D7970 | Excision of hyperplastic tissue - per arch | 66 |
| D7971 | Excision of pericoronal gingiva | 36 |
| | **LIMITED ORTHODONTIC TREATMENT** | |
| D8010 | Limited orthodontic treatment of the primary dentition | 1,500 |
| D8020 | Limited orthodontic treatment of the transitional dentition | 1,500 |
| D8030 | Limited orthodontic treatment of the adolescent dentition | 1,500 |
| D8040 | Limited orthodontic treatment of the adult dentition | 1,500 |
| | **INTERCEPTIVE ORTHODONTIC TREATMENT** | |
| D8050 | Interceptive orthodontic treatment of the primary dentition | 1,500 |
| D8060 | Interceptive orthodontic treatment of the transitional dentition | 1,500 |
| | **COMPREHENSIVE ORTHODONTIC TREATMENT** | |
| D8070 | Comprehensive orthodontic treatment of the transitional dentition | 1,500 |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition | 1,500 |
| D8090 | Comprehensive orthodontic treatment of the adult dentition | 2,000 |
| | **MINOR TREATMENT TO CONTROL HARMFUL HABITS** | |
| D8210 | Removable appliance therapy | 750 |
| D8220 | Fixed appliance therapy | 750 |
| | **OTHER ORTHODONTIC SERVICES** | |
| D8660 | Pre-orthodontic treatment visit | 40 |
| D8670 | Periodic orthodontic treatment visit (as part of contract) | 0 |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of retainer(s)) | 240 |
| † | Orthodontic records fee | 265 |
| | **UNCLASSIFIED TREATMENT** | |
| D9110 | Palliative (emergency) treatment of dental pain - minor procedure | 8 |
| D9120 | Fixed partial denture sectioning | 70 |
| | **ANESTHESIA** | |
| D9210 | Local anesthesia not in conjunction with operative or surgical procedures | 0 |
| D9211 | Regional block anesthesia | 0 |
| D9212 | Trigeminal division block anesthesia | 0 |
| D9215 | Local anesthesia | 0 |
| D9220 | Deep sedation/general anesthesia - first 30 minutes | 160 |
| D9221 | Deep sedation/general anesthesia - each additional 15 minutes | 68 |
| D9241 | Intravenous conscious sedation/analgesia - first 30 minutes | 170 |
| D9242 | Intravenous conscious sedation/analgesia - each additional 15 minutes | 42 |
| | **PROFESSIONAL CONSULTATION** | |
| D9310 | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | 0 |
| | **PROFESSIONAL VISITS** | |
| D9430 | Office visit for observation (during regularly scheduled hours) - no other services performed | 0 |
| D9440 | Office visit, after regularly scheduled hours | 40 |
| D9450 | Case presentation, detailed and extensive treatment planning | 0 |
| | **MISCELLANEOUS SERVICES** | |
| D9940 | Occlusal guard, by report | 200 |
| D9942 | Repair and/or reline of occlusal guard | 65 |
| D9951 | Occlusal adjustment - limited | 15 |
| D9952 | Occlusal adjusment - complete | 60 |
| ★ | Broken appointment per 30 minutes (without 24-hour notice) | 20 |
| | **BLEACHING** | |
| D9972 | External bleaching - per arch | 185 |

**FOOTNOTES**

† Please report under code D8999 "Unspecified orthodontic procedure, by report". Records include all diagnostic procedures, such as cephalometric films, full mouth x-rays, models, and treatment plans.

★ Please report under code D9999 "Unspecified adjunctive procedure, by report."

◆ Charges for the use of precious (high noble) or semi precious (noble) metal are not included in the copayment for crowns, bridges, pontics, inlays and onlays. The decision to use these materials is a cooperative effort between the provider and the patient, based on the professional advice of the provider. Providers are expected to charge no more than an additional $125 for these materials.

# SCHEDULE OF EXCLUSIONS & LIMITATIONS

**EXCLUSIONS:**

**Except as specifically provided in this Certificate, no coverage will be provided for services, supplies or charges:**

1. Not specifically listed in the Schedule of Benefits as a Covered Service.
2. Provided to Members outside of the office in which the Member is enrolled and which are not pre-authorized by the Company (including specialty care services).
3. Which in the opinion of the treating dentist, or the Company, are not clinically necessary, or do not have a reasonable, favorable prognosis.
4. That are necessary due to lack of cooperation with the treating dentist, or failure to comply with a professionally prescribed Treatment Plan.
5. Started or incurred prior to the Member's eligibility under the Company or after the Termination Date of coverage with the Company.
6. For consultations by a Specialty Care Dentist for services not specifically listed on the Schedule of Benefits as a Covered Service.
7. That do not meet accepted standards of dental treatment, which are Experimental or Investigative in nature or are considered enhancements to standard dental treatment as determined by the Company.
8. For hospitalization and associated costs for rendering services in a hospital.
9. Determined by the Company to be the responsibility of Worker's Compensation or employer's liability or health care plan, or payable under any Federal Government or state program, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy, or for services for which benefits are payable under any other insurance.
10. For prescription or non-prescription drugs, home care items, vitamins or dietary supplements.
11. Which are principally Cosmetic in nature, including, but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures as determined by the Company.
12. For diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint (TMJ) syndrome and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint.
13. For services and/or appliances that alter the vertical dimension or alter, restore or maintain the occlusion, including, but not limited to, full mouth rehabilitation, splinting, appliances or any other method.
14. That restore tooth structure lost due to attrition, erosion or abrasion.
15. For replacement of lost, missing, stolen or damaged prosthetic device or orthodontic appliance or for duplicate dentures, prosthetic devices or any duplicative device.
16. For the following, which are not included as orthodontic benefits – retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient non-cooperation, repair of orthodontic appliances, replacement of lost or stolen appliances, special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders), myofunctional therapy, cases involving orthognathic surgery, extractions for orthodontic purposes, and treatment in excess of twenty-four (24) months.
17. For implants, surgical insertion and/or removal of, and any appliances and/or prosthetics attached to implants.
18. Required because of, or in connection with, acts of war, declared or undeclared.
19. For elective procedures, including, but not limited to, prophylactic extractions of third molars.

**LIMITATIONS**

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

1. Referral to a Specialty Care Dentist is limited to orthodontics, oral surgery, periodontics, endodontics, and pediatric dentists.
2. Coverage for referral to a pediatric Specialty Care Dentist ends on a Member's 7th birthday. However, exceptions for physical or mental handicaps or medically compromised children, when confirmed by a physician, may be considered on an individual basis with prior approval from the Company.
3. Member must remain in the Plan during the period of time they are undergoing orthodontic treatment. Any early termination can result in additional charges for all unfinished work. This limitation only applies to subscriber termination, not group termination.
4. Sealants – one (1) per tooth per three (3) year period through age ten (10) on permanent first molars and through age fifteen (15) on permanent second molars.
5. In the case a Dental Emergency involving pain or a condition requiring immediate treatment occurring more than fifty (50) miles from the Member's home, the Plan covers necessary diagnostic and therapeutic dental procedures administered by a dentist up to a maximum of $100 for each emergency visit.
6. Periodontal maintenance following active periodontal therapy - two (2) per twelve (12) consecutive months in combination with routine prophylaxis.
7. Periodontal scaling and root planing - one (1) per twenty-four (24) consecutive month period per area of the mouth.
8. Surgical periodontal procedures - one (1) per thirty-six (36) consecutive month period per area of the mouth.
9. Root canal retreatment – one (1) per tooth per lifetime.
10. Panoramic or full mouth x-rays - one (1) every three (3) years.
11. One (1) set of bitewing x-rays per six (6) consecutive months.
12. Prophylaxis - one (1) per six (6) consecutive months, unless otherwise specified in the Schedule of Benefits.
13. Fluoride treatment - one (1) per six (6) consecutive months through age eighteen (18).
14. Crown lengthening - one (1) per tooth per lifetime.
15. Denture relining or rebasing - integral if provided within six (6) months of insertion by the same dentist. This limitation does not apply to immediate dentures.
16. Subsequent denture relining or rebasing - limited to one (1) every thirty-six (36) consecutive months thereafter.
17. Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bony or complete bony impactions).

# DAVIS VISION *Benefits You Can See*

## 1. DISCOUNT PROGRAM

Davis Vision is pleased to provide you with a low-cost, traditional vision Discount Program that provides significant discounts on eye exams, lenses, frames and additional eyewear options. Simply visit a participating vision provider and present your discount card and Control Code. With nearly 26,000 participating vision providers, you can find a provider near you by calling our toll-free Interactive Voice Response (IVR) system or visiting the Davis Vision website at **www.davisvision.com**. For more details, see the Accessing Benefit and Provider Information section on the reverse side.

The Discount Program entitles you to the following discounts off usual and customary fees:

| | |
|---|---|
| **Vision Plan:** | Vantage Affinity Discount Program |
| **Control Code/Client Control Number:** | 7602 |
| **Co-payment:** | N/A, discount plan is 100% member paid at the time of service |
| **Lens 123®:** | Discounts on replacement contact lenses from 1-800-LENS123 |
| **Laser Vision Correction:** | Discounts from participating laser vision providers |

| DAVIS VISION DISCOUNT SCHEDULE | MEMBER COST |
|---|---|
| **Eye examination** | |
| Complete Examination | 15% off Usual & Customary |
| Contact Lens Examination | 15% off Usual & Customary |
| **Frame** | |
| Frame—up to $70.00 retail | $40.00 |
| Frame—over $70.00 retail | $40.00 plus 10% off the amount over $70.00 |
| **Spectacle Lenses** | |
| Single Vision Lenses | $35.00 |
| Bifocal Lenses | $55.00 |
| Trifocal Lenses | $65.00 |
| Lenticular Lenses | $110.00 |
| **Options (Add to Spectacle Lenses Prices)** | |
| Standard Progressive Lenses | $75.00 |
| Premium Progressive Lenses | $125.00 |
| Polarized | $75.00 |
| High Index Lenses | $55.00 |
| Glass Lenses | $18.00 |
| Polycarbonate Lenses | $30.00 |
| Blended Invisible Bifocals | $20.00 |
| Intermediate Vision Lenses | $30.00 |
| Scratch Resistant Coating | $15.00 |
| Anti-Reflective Treatment | $45.00 |
| Ultraviolet Coating | $15.00 |
| Solid Tint | $10.00 |
| Gradient Tint | $12.00 |
| PGX Lenses | $35.00 |
| Plastic Photosensitive Lenses | $65.00 |
| **Contact Lenses** | |
| Conventional | 20% off Usual & Customary |
| Disposable/Planned Replacement | 10% off Usual & Customary |
| Lens 123® | Free membership with up to 60% off Retail Prices |

*Discount Schedule continued . . .*

DAVIS VISION
THE EYECARE ADVANTAGE

This card entitles the bearer and family to special discounted pricing

Name _____
Group United Concordia
Control Code 7602
Signature _____

*Benefits you can see.*

*Discount Schedule continued . . .*

**Other Products**

| | |
|---|---|
| Non-Prescription Sunglasses | 20% off Usual & Customary |
| Other Ancillary Products/Solutions | 10% off Usual & Customary |
| Laser Vision Correction | Up to 25% off Usual & Customary |

Note: Any special lens designs, materials, powers and frames may require additional payment.

## 2. LENS 123®

Lens 123® is a mail order program that allows you to enjoy the guaranteed lowest prices on replacement contact lenses—save up to 60% off retail prices. Members can conveniently call 1-800-LENS123 with a current prescription for this value-added service. The Lens 123® contact lens replacement program is endorsed by the industry's major manufacturers.

## 3. LASER VISION CORRECTION

Davis Vision's Laser Vision Correction program provides substantial discounts on laser vision correction procedures. Members are entitled to savings of up to 25% off usual and customary fees or a 5% discount off a center's advertised special through a network of preeminent physicians affiliated with Eye Centers of Excellence. (Some centers provide a flat fee equating to these discount levels.) See below for information on finding a participating laser vision provider near you.

## HOW THE DISCOUNT PROGRAM WORKS WITH YOUR PLAN

You may choose from a list of Davis Vision contracted private practice providers or contracted retail locations for discounts on eyewear. If you already have a vision examination benefit as part of your health plan, you may use a network provider in your health plan network for your examination. Then use a Davis Vision contracted provider for your eyewear purchases (eyeglasses, etc.) and maximize your savings (you should verify whether or not the Davis Vision provider accepts outside prescriptions prior to your appointment).

## ACCESSING BENEFIT AND PROVIDER INFORMATION

Whether you're looking for a participating vision provider or want more information about the discount plan, Davis Vision offers a number of convenient ways for you to get the information you need, when you need it.

### AUTOMATED SERVICES (available 24/7)

**Online**—To access the United Concordia Davis Vision Discount Member Menu, visit **www.davisvision.com** and select "Find a Provider". In the second box, enter Control Code 7602 and click "Submit". From the Member Menu you can find a provider, review your benefits, obtain a confirmation number for laser surgery, take a satisfaction survey, visit Lens 123® to buy replacement contact lenses and more!

**Over the phone**—To access the automated Interactive Voice Response (IVR) system, call Davis Vision Customer Service at **1-877-923-2847** and enter Client Control Number 7602 when prompted. Select the appropriate menu option using your phone's touch pad.

### CUSTOMER SERVICE

To speak with a customer service representative, call Davis Vision Customer Service at 1-877-923-2847. Enter Client Control Number 7602 when prompted. At the main menu, press "0". Our representatives are available to assist you from 8 a.m. to 11 p.m. ET Monday through Friday, 9 a.m. to 4 p.m. ET Saturday and 12 p.m. to 4 p.m. ET Sunday.

DAVIS VISION™
THE EYECARE ADVANTAGE

**CUSTOMER SERVICE**
**1-877-923-2847**

UNITED CONCORDIA
Insuring America's Dental Health

CAERE03/06 • Available Concordia products are underwritten by United Concordia Insurance Company in OK and written on OK policy forms 9802 (06/01) and 9802L (06/01).

# United Concordia Dental Plans of California, Inc.

*21700 Oxnard Street, Suite 500*
*Woodland Hills, CA 91367*
*866-357-3304*
www.unitedconcordia.com

## COMPROBANTE DE COBERTURA COMBINADO Y FORMULARIO DE DIVULGACIÓN

Este Comprobante de Cobertura Combinado y Formulario de Divulgación constituye únicamente un resumen de este Plan dental. El contrato del plan dental del Grupo debe ser consultado para determinar los términos y condiciones de cobertura exactos.

El Comprobante de Cobertura Combinado y Formulario de Divulgación revela los términos y condiciones de la cobertura y el solicitante tiene el derecho a ver el comprobante de cobertura antes de la inscripción.

Los individuos con necesidades de cuidado de salud especiales deben leer esas secciones que aplican a ellos.
Se proveerá a su petición una copia muestra del contrato de Plan.

Los Beneficios de su Plan pueden diferir de la cobertura especificada en este folleto. Por favor recurra a cualesquier anexos incluidos en este folleto.

Si usted pertenece a un grupo con 50 o menos empleados, consulte por favor el anexo Beneficio del Plan de Salud y Matriz de Cobertura.

**Por favor lea la siguiente información para que usted comprenda cómo trabaja este programa y cómo pueden obtenerse los beneficios.**

**CA9805-B (08/04)**

# COMPROBANTE DE COBERTURA

## INTRODUCCIÓN

Este Comprobante de Cobertura proporciona información sobre Su cobertura dental. Léalo detenidamente y guárdelo en un lugar seguro con Sus demás documentos valiosos. Examínelo para conocer Sus beneficios y para cuando tenga alguna pregunta específica en cuanto a Su cobertura.

Para ofrecer estos beneficios, Su Grupo ha firmado un Contrato Colectivo con United Concordia. Los beneficios están disponibles mientras la Prima para Usted y los Dependientes inscritos esté pagada y se satisfagan las obligaciones señaladas en el Contrato Colectivo. En caso de conflicto entre este Comprobante de Cobertura y el Contrato Colectivo, el Contrato Colectivo predominará. Este Comprobante de Cobertura no es un resumen de la descripción del plan bajo la Ley para la Seguridad del Ingreso de Jubilación del Empleado (ERISA, por sus siglas en inglés).

Si tiene alguna duda sobre Su cobertura o beneficios, o si tiene preguntas relacionadas con información general, disponibilidad de Dentistas Concordia Plus o información sobre Beneficios, llame sin costo alguno a nuestro Departamento de Servicio al Cliente al:

866-357-3304

También puede entrar a nuestro sitio Web en:

www.unitedconcordia.com

Los formularios de reclamación deberán enviarse a:

United Concordia Companies, Inc.
PO Box 10194
Van Nuys, CA 91410

## CONTENIDO



ADJUNTOS:

LISTA DE BENEFICIOS
LISTA DE EXCLUSIONES Y LIMITACIONES

## DEFINICIONES

Ciertos términos que se usan a lo largo de este Comprobante de Cobertura comienzan con letras mayúsculas. Cuando estos términos aparezcan con mayúscula, utilice las siguientes definiciones a fin de entender su significado, ya que aplican a Sus beneficios y la forma en que funciona el plan dental.

| | |
|---|---|
| **Comprobante de Cobertura Combinado y Formulario de Divulgación ("Comprobante de Cobertura")** | Este documento, y sus cláusulas adicionales, listas, anexos y/o endosos, si los hubiera, en los cuales se describe la cobertura adquirida de la Compañía por el Asegurado. |
| **Compañía** | United Concordia Dental Plans of California, Inc. También se le denomina "Nosotros", "Nuestro" o "Nos". |
| **Asegurado** | Organización que firma la Póliza Colectiva. También se le denomina como "Su Grupo". |
| **Coordinación de Beneficios (COB)** | Un método para determinar los beneficios de los Servicios Cubiertos cuando el Afiliado queda cubierto por más de un plan, a fin de prevenir la duplicación del pago de modo que no se pague más que el gasto incurrido. |
| **Copagos** | Aquellos cargos establecidos en la Lista de Beneficios que el Afiliado es responsable por pagar al dentista que atiende. |
| **Cosmético** | Aquellos procedimientos que se encargan, principalmente, de mejorar o modificar el aspecto del Afiliado. |
| **Servicio(s) Cubierto(s)** | Un servicio o provisión especificada en la Lista de Beneficios por los cuales estarán cubiertos los beneficios sujetos a la sección de Beneficios de este Comprobante de Cobertura, cuando es proporcionado por un dentista de la red de acuerdo con los términos del Comprobante de Cobertura. |
| **Emergencia Dental** | Servicios que diagnostican y tratan una condición dental, la cual es manifestada por síntomas agudos de suficiente seriedad, incluyendo dolor agudo, tal que la ausencia de atención dental inmediata puede ser razonablemente esperada a resultar en alguna de las siguientes: (a) Poner en alto peligro la salud del individuo, (b) Impedimento crónico de las funciones del cuerpo, o (c) disfunción crónica de un órgano o parte del cuerpo. |
| **Dentalmente Necesario** | Un servicio dental o procedimiento determinado por un dentista ya sea para establecer o mantener la salud dental de un paciente. Tales determinaciones están basadas en el juicio de diagnostico profesional del dentista y los estándares de cuidado que prevalecen en la comunidad profesional. |

**Dependiente(s)**

Dueno's del Certificado cónyuge o doméstico por vida como definido por el Dueno de la Póliza y/o la ley del estado y cualquier hijo, hijo adoptivo or hijastro de un Dueno del Certificado, o un hijo sujeto a una orden de la corte or puesto por una agencia adminstrativa con un Dueno de Certificado:
(a) hastamesque el hijo llega a la edad limitada de 19; o
(b) hasta el final del mes en que el/ella llega a la edad de 23 si el/ella es estudiante de tiempo completo en un intitucion educativa acreditada y principalmente depende de el Dueno del Certificado de mantenimiento o sosten; o
(c) a cualquiera edad si el/ella es o continua siendo los siguiente de ambos, incapaz de mantenerse con empleo por descapacidades mentales o fisicas y depende principalment del mantenimiente y sosten del Dueno del Certificado.

**Fecha Efectiva**

La fecha en que comienza el Contrato Colectivo o comienza la cobertura de Afiliado(s) inscrito(s).

**Exclusión(es)**

Servicios, suministros o gastos que el Contrato Colectivo no cubra, según lo establezca la Lista de Exclusiones y Limitaciones.

**Experimental o de Investigación**

El uso de cualquier tratamiento, procedimiento, instalación, equipo, fármaco, o dispositivo de uso del fármaco o suministro que la Compañía determine que no sea un tratamiento de cuidado dental estándar aceptable.

**Período de Gracia**

Un período de no menos de 31 días después de que se vence el pago de la Prima conforme al Contrato, en cuyo período el Asegurado puede hacer dicho pago y durante el cual continúa la protección del Contrato Colectivo, sujeta al pago de la Prima al final del Período de Gracia.

**Contrato Colectivo**

Convenio entre la Compañía y el Asegurado, según el cual el Subscriptor cumple con los requisitos para inscribirse.

**Dentista Dentro de la Red**

Un Consultorio Dental Principal o Dentista Especialista.

**Limitación(es)**

El máximo de veces o límite de edad que limita un Servicio Cubierto establecido en la Lista de Exclusiones y Limitaciones.

**Cargo Máximo Permitido**

La cantidad máxima que el Plan permitirá para un Servicio Cubierto específico. Los Cargos Máximos Permitidos pueden variar según el contrato entre la Compañía y el Dentista particular que presta el servicio. Los Cargos Máximos Permitidos por

| | |
|---|---|
| | Servicios Cubiertos prestados por Dentistas fuera de la red pueden ser iguales o mayores que tales cargos o Servicios Cubiertos prestados por Dentistas dentro de la red para ayudar a limitar los costos de desembolso de Afiliados que eligen Dentistas fuera de la red. |
| **Afiliado(s)** | Suscriptor y su(s) Dependiente(s). |
| **Dentistas Fuera de la Red/ Proveedor No Participante** | Cualquier dentista general o especialista que no haya firmado un contrato con la Compañía. |
| **Plan** | Beneficios dentales de acuerdo con este Comprobante de Cobertura y con la Lista de Exclusiones y Limitaciones y la Lista de Beneficios adjuntas. |
| **Prima** | El pago que el Asegurado debe remitir a la Compañía a cambio de la cobertura de los Afiliados del Asegurado. |
| **Consultorio Dental/Proveedor Principal** | Consultorio aprobado de un Dentista Principal quien ha celebrado un contrato con la Compañía y quien ofrece servicios dentales a los Afiliados. |
| **Dentista Principal** | Un dentista general cuyo consultorio ha celebrado un acuerdo con la Compañia y en virtud del cual se compromente a brindar los servicios dentales que se describen en la Lista de Beneficios a los Afiliados por una tarifa mensual más los Copagos y suplementos aplicables como pago total de los servicios prestados. |
| **Fecha de Renovación** | La fecha en que se renueva el Contrato Colectivo. También conocida como fecha de aniversario. |
| **Lista de Beneficios** | Resumen adjunto de Servicios Cubiertos, y copagos aplicables a beneficios pagaderos conforme al Plan. |
| **Lista de Exclusiones y Limitaciones** | La lista anexa de Exclusiones y Limitaciones Aplicable a los beneficios, servicios, provisiones o cargos conforme al Plan. |
| **Dentistas Especialistas** | Un dentista especializado quien está capacitado en una de las áreas de especialidad de periodontología, cirugía oral, ortodoncia, endodoncia, y pediatría y quien ha celebrado un contrato con la Compañía para aceptar pagos negociados más cualesquier copagos aplicables, como pago total por Servicios Cubiertos provistos al Afiliado. |
| **Subscriptor** | Una persona que se ha inscrito a Sí misma y a sus Dependientes para la cobertura dental y para quien los pagos de la Prima son debidos y pagaderos. También se le denomina "Usted" o "Su" o "Sí mismo(a)". |

| | |
|---|---|
| **Proveedor Terminado** | Un doctor que proveía servicios conforme al contrato que ya no está asociado con el Plan. |
| **Fecha de Terminación** | La fecha en que termina la cobertura dental para un Afiliado o termina el Contrato Colectivo. |

## ELEGIBILIDAD E INSCRIPCIÓN -- CUÁNDO COMIENZA LA COBERTURA

### Inscripción nueva

Si usted ya ha llenado los requisitos de elegibilidad de su Contrato Colectivo cuando dé comienzo la Póliza Colectiva y Nos haya proporcionado Su información de inscripción, Su cobertura y la cobertura de Sus Dependientes comenzarán en la Fecha Efectiva del Contrato Colectivo, siempre y cuando Nosotros recibamos la Prima.

Si Usted se afilia al Grupo o es empleado después de la Fecha Efectiva inicial del Contrato Colectivo, a fin de ser elegible para inscribirse, deberá llenar primero los requisitos de elegibilidad de Su Grupo. Su Grupo le informará acerca de estos requisitos.

Deberá proporcionar la información de inscripción requerida sobre Usted mismo y sobre Sus Dependientes en un plazo de 31 días después de la fecha en que haya llenado estos requisitos. Sus Dependientes también deberán llenar los requisitos que se señalan en la definición de Dependiente que se encuentra en la sección de Definiciones de este Comprobante de Cobertura.

Su cobertura y la de Sus Dependientes comenzarán en la fecha que se especifica en la información de inscripción que Nos ha proporcionado, siempre y cuando la Prima haya sido pagada.

La Compañía no está obligada a pagar beneficios por ningún servicio que haya comenzado antes de la Fecha Efectiva de la cobertura de un Afiliado. Los procedimientos de varias sesiones son considerados como "comenzados" cuando el procedimiento no puede ser revertido. Por ejemplo, para coronas, puentes y prótesis removibles, el procedimiento comienza cuando las piezas dentarias están preparadas y se han tomado las impresiones. Para tratamientos de endodoncia, el procedimiento comienza cuando se abre el diente y se extrae la pulpa. Los procedimientos que hayan comenzado antes de la Fecha Efectiva del Afiliado son responsabilidad del Afiliado o de una compañía aseguradora previa.

### Cambios en la Inscripción

Después de Su inscripción inicial, hay ciertos eventos de cambio de vida que le permiten añadir más Dependientes. Estos eventos son:

- nacimiento
- adopción
- orden judicial de colocación o custodia
- cambio de estatus estudiantil de un hijo
- matrimonio
- companero domestico del Duenoo del Certificado, como es definido por Seccion 297 del Codigo Familiar de California.

Para inscribir a un nuevo Dependiente como resultado de uno de estos eventos, Usted deberá notificar a Su Grupo y proporcionar la información de cambio de inscripción requerida en un plazo de 31 días después de la fecha en que adquirió al Dependiente. Su Dependiente también deberá llenar los requisitos que se señalan en la definición de Dependiente que se encuentra en la sección de Definiciones de este Comprobante de Cobertura.

Excepto niños recién nacidos o adoptivos, la cobertura para el nuevo Dependiente comenzará en la fecha especificada en la información de inscripción que Nos proporcione mientras la Prima esté pagada.

Los hijos recién nacidos de un Afiliado serán considerados inscritos a partir del momento del nacimiento. Los hijos adoptivos se consideran inscritos a partir de la fecha de adopción o colocación, excepto aquellos adoptados o colocados dentro de los 31 días a partir del nacimiento, los cuales serán considerados como Dependientes inscritos a partir del momento del nacimiento. A fin de que la cobertura de hijos recién nacidos o adoptivos continúe más allá del primer período de 31 días, se Nos deberá proporcionar la información de inscripción del niño, y la Prima requerida deberá pagarse dentro del período de 31 días.

Si usted tiene un hijo Dependiente quien es estudiante de tiempo completo, se debe proveer la prueba de su estatus de estudiante dentro de 31 días después que él/ella ha cumplido los 19 años de edad. Este comprobante del estatus de estudiante no será requerido más frecuente que anualmente después de los dos años iniciales de la petición inicial.

En el caso de un/a hijo/a Dependiente afiliado/a que tenga alguna lesión, enfermedad o condición física o mental discapacitante, también deberá proporcionarnos documentación que compruebe que dicha persona depende de Usted para su manutención y sustento debido a su condición, dentro de un plazo de 60 días a partir de la fecha en que la Compañía le notifique que la cobertura de su hijo/a Dependiente terminará al llegar al límite de edad, a menos que el Afiliado entregue comprobantes de alguna lesión, enfermedad, condición o discapacidad física o mentalmente incapacitante. La Compañía enviará la notificación al Afiliado al menos 90 días antes de la fecha en que el/la hijo/a Dependiente llegue a la edad límite. Si el Dependiente es estudiante de tiempo completo en una institución educativa acreditada, deberá proporcionarnos pruebas en un plazo de 31 días a partir de que el Dependiente alcance la edad límite para estudiantes. Tal evidencia será requerida en base a la información provista por el medico del Afiliado pero no mas frecuente que anualmente después de un periodo de espera de dos años una vez que es provista la evidencia inicial.

La cobertura del Dependiente sólo puede terminar cuando se presentan ciertos eventos de cambio de vida, incluyendo muerte, divorcio o alcanzar la edad límite o durante períodos de inscripción abierta.

## Inscripción Tardía

Si Usted o Sus Dependientes no están inscritos en el plazo de 31 días a partir de la elegibilidad inicial o de un evento de cambio de vida, ni Usted ni Sus Dependientes podrán inscribirse sino hasta el siguiente período de inscripción abierta para Su Grupo. Si se requiere que Usted proporcione cobertura a un hijo Dependiente de acuerdo con una orden judicial, se le permitirá inscribir al hijo Dependiente sin tomar en cuenta las restricciones de la temporada de inscripción.

## Cargos de Prepago

Cargos de prepago son el pago periódico de la Prima que Su Grupo nos paga por la cobertura bajo este Plan. Su Grupo es responsable por remitir la cantidad adecuada de la Prima directamente a Nosotros. El pago puede ser en efectivo o cheque y presentado en persona, por correo o transferencia. Para más detalles puede consultar a Su Grupo. El cobro del prepago no es lo mismo que un Copago. Los copagos son Su responsabilidad.

Los suscriptores deben contactar al Asegurado para información referente a cualesquier cantidades a ser retenidas de su salario o cualesquier cantidades que Usted Paga a Su Grupo por este Plan.

## CÓMO FUNCIONA EL PLAN DENTAL

### Instalaciones

El Consultorio Dental Principal es la instalación principal bajo este Plan. Para determinar su Consultorio Dental Principal, recurra a la sección de Elección de Proveedores de este Comprobante de Cobertura.

### Elección de Proveedor

Cuando se inscribe para la cobertura dental, debe seleccionar un Consultorio Dental Principal para Usted y Sus Dependientes. Sus Dependientes no tienen que elegir el mismo consultorio que Usted o que Sus otros Dependientes. Si Usted o Sus Dependientes no seleccionan un consultorio en la inscripción, serán asignados a un consultorio en una ubicación conveniente al código postal de Su hogar. El (los) Consultorio(s) Dental(es) Principal(es) será(n) notificado(s) de Su selección o asignación.

Para encontrar un Consultorio Dental Principal, visite Find a Dentist en nuestro sitio web en www.unitedconcordia.com o llame a nuestro Sistema de Repuesta de Voz Interactiva al número gratuito en la sección de introducción de este Comprobante de Cobertura o recurra a la lista de Dentista Principal en sus materiales de inscripción.

Una vez inscrito, Usted recibirá una tarjeta de identificación (ID) u otra información indicando Su número de identificación (ID) de contrato, número de plan y grupo, los nombres de los Consultorios Dentales Principales que seleccionaron Usted y Sus Dependientes o que les fueron asignados. Cuando llame al consultorio para programar una cita, avísele al consultorio que tiene cobertura de United Concordia. Cuando visite el consultorio dental, presente su tarjeta de identificación (ID) o comuníquele a Su consultorio Su número de identificación, número de plan y grupo. Si Su dentista tiene preguntas sobre Su elegibilidad o beneficios, pídale al consultorio que llame sin costo a Nuestro Sistema de Repuesta de Voz Interactiva o que visite Dental Inquiry en Nuestro sitio Web en www.unitedconcordia.com.

**ADVERTENCIA: Usted debe ir a Su Consultorio Dental Principal u obtener una remisión del Consultorio Dental Principal a un dentista dentro de la red para tener cobertura por este Plan. Si Usted recibe servicios de un Dentista Fuera de la Red, los servicios no serán cubiertos por este Plan. Las únicas excepciones son si Usted tiene una Emergencia Dental o si un Dentista Principal o Dentista especialista no está disponible en su área. Para detalles en esta situación vea la sección titulada Emergencia Dental.**

### Proveedores Posteriores

Usted o Sus Dependientes pueden requerir cambiar Su Consultorio Dental Principal en cualquier momento. Para hacer un cambio, llame sin costo a nuestro Centro de Servicio al Cliente, marcando el número que aparece en la sección de Introducción de este Comprobante de Cobertura, o visite nuestro sitio Web en www.unitedconcordia.com. Se le informará la fecha en que Su transferencia será efectiva. El nuevo consultorio seleccionado también será notificado. Su nuevo proveedor debe estar activo antes de buscar servicios de Su nuevo Consultorio Dental Principal.

Si Usted o Sus Dependientes están inscritos con un Consultorio Dental Principal que ya no participa en el Plan, le notificaremos y asistiremos a Usted o a Sus Dependientes con la selección de otro Consultorio Dental Principal.

## Reembolso del Proveedor

Nosotros reembolsamos a Su Consultorio Dental Principal de forma prepagada por Afiliados inscritos en sus consultorios. Los Consultorios Dentales Principales también pueden recibir pago adicional para los Servicios Cubiertos cuando los servicios sean provistos bajo el Plan.

Los Dentistas de Cuidado Especial son reembolsados al Cargo Máximo Permitido por Servicios Cubiertos calificables para una remisión. No se proveen más incentivos o bonos financieros a los Dentistas Dentro de la Red. Si desea obtener mayor información del reembolso del proveedor puede contactar al número gratuito del Servicio al Cliente en la portada de este Comprobante de Cobertura.

## Continuidad de Cuidado

Afiliados Actuales:
Los Afiliados actuales pueden tener el derecho al beneficio de terminación de cuidado con Su Proveedor Terminado para ciertos condiciones dentales especificas. Llame al Plan marcando 866-357-3304 para ver si Usted es elegible para este beneficio. Puede solicitar una copia de la Política de Continuidad de Cuidado del Plan. Usted debe hacer una petición específica para continuar bajo el cuidado de Su Proveedor Terminado. No se nos requiere que continuemos Su cuidado con ese proveedor si Usted no tiene derecho bajo nuestra póliza o no podemos llegar a un acuerdo con Su proveedor terminado en los términos referentes a Su cuidado de acuerdo con la ley de California.

Afiliados Nuevos:
Un Afiliado nuevo puede tener el derecho al beneficio de terminación de cuidado cual Usted tiene una remisión escrita de Su Dentista con Su Proveedor fuera de la red para ciertas condiciones dentales específicas. Por favor llame al Plan al 866-357-3304 para ver si Usted tiene derecho a este beneficio. Puede solicitar una copia de la Política de Continuidad de Cuidado del Plan. Usted debe hacer una petición específica para continuar bajo el cuidado de Su proveedor actual. No se nos requiere que continuemos Su cuidado con ese proveedor si Usted no tiene derecho bajo nuestra póliza o no podemos llegar a un acuerdo con Su proveedor en los términos referentes a Su cuidado de acuerdo con la ley de California. Esta política no aplica a Afiliados nuevos de un contrato de suscriptor individual.

## Remisiones

El Consultorio Dental Principal coordinará el cuidado dental para Usted y Sus Dependientes. No se requieren formularios de reclamo de Su parte. Para que se cubran los servicios dentales, el cuidado debe ser provisto por su Dentista Principal asignado o por un Dentista de Cuidado Especializado al Principal. Las únicas excepciones son si Usted tiene una emergencia dental o si el Dentista Principal o el Dentista de Cuidado Especializado no está

disponible en Su área. Vea la próxima sección titulada Emergencia Dental para detalles en esta situación.

Cuando se necesita el cuidado especial como tratamiento quirúrgico de encías o endodoncia, el Dentista Principal puede desarrollar el procedimiento o puede referirlo a un especialista. Todas las remisiones deben ser hechas a un Dentista de Cuidado Especial participante. Su Dentista de Cuidado principal le dará una remisión escrita para llevarla con el Dentista de Cuidado Especial. El Dentista de Cuidado Especial hará el tratamiento y nos presentará un reclamo y la remisión para su proceso. La remisión está limitada a endodoncia, ortodoncia, periodontología, cirugía oral y dentistas pediatras de Cuidado Especial.

Si tuviera Usted alguna pregunta acerca de Su cobertura, elegibilidad o una reclamación específica, póngase en contacto con Nosotros en la dirección y número de teléfono que aparecen en la sección de Introducción de este Comprobante de Cobertura o inicie sesión en My Dental Benefits (Mis Beneficios Dentales) en www.unitedconcordia.com.

## Emergencia Dental

Una Emergencia Dental es una situación donde usted tiene un dolor agudo, inflamación, o hemorragia en Su boca. Si tiene una Emergencia Dental, debe contactar a Su Consultorio Dental Principal. Si no puede contactar a Su Consultorio Dental Principal, debe contactar al número de Servicio al Cliente en la portada de este Comprobante de Cobertura para hacer arreglos de tratamiento para Su Emergencia Dental o vaya con un dentista general ubicado convenientemente. Una Emergencia Dental no requiere autorización previa. Pídale al consultorio dental que llame a la Unidad de Servicio al Cliente para verificar la cobertura al número telefónico anotado en la portada de este Comprobante de Cobertura. Obtenga una factura detallada del consultorio dental para enviar a la dirección en la sección de Introducción de este Comprobante de Cobertura. El Plan cubrirá ciertos procedimientos de diagnostico y terapéuticos de acuerdo con la Lista de Beneficios. Su costo de desembolso será limitado a cualquier Copago aplicable en la Lista de Beneficios. Los Afiliados deben regresar a Su Consultorio Dental Principal por cualquier cuidado de seguimiento necesario.

## Provisiones de Reembolso del Afiliado

En caso que un Consultorio Dental Principal o Dentista Especialista no está disponible, la compañía puede autorizar el tratamiento por un dentista fuera de la red. El Afiliado solo es responsable por el Copago aplicable, como es indicado en la Lista de Beneficios adecuada para el Afiliado. Si el Afiliado ha pagado al Dentista Fuera de la Red, la Compañía reembolsará al Suscriptor la diferencia entre el cargo y el Copago como está definido en la Lista de Beneficios adecuada. Los Afiliados deben enviar un formulario de reclamación al domicilio que aparece en la carátula de este Comprobante de Cobertura, en el plazo de 60 días a partir de la fecha en que obtuvieron la autorización de tratamiento, tal como se describió anteriormente, o en el plazo de 60 días si se trata de una Emergencia Dental atendida por un Dentista Fuera de Red. La mayoría de los dentistas que atienden proveerán un formulario de reclamo completo por Usted. Sin embargo, si necesita obtener un formulario de reclamo, lo puede hacer en nuestro sitio web en www.unitedconcordia.com.

### Responsabilidad de los Afiliados en caso de Incumplimiento de Pago

Todos los contratos entre la compañía y el Dentista Principal o Dentista de Cuidado Especial dicen que bajo ninguna circunstancia los Afiliados deben ser responsables a cualquier dentista por cualquier cantidad debida de la Compañía al dentista. En cualquier momento donde la Compañía incumple o se niega a pagar al dentista, tal disputa es únicamente entre el dentista y la Compañía y el Afiliado no es responsable por cualquier dinero que la Compañía incumple o se niega a pagar.

## BENEFICIOS

### Lista de Beneficios

Sus beneficios están detallados en la Lista de Beneficios anexa a este Comprobante de Cobertura. Su Lista de Beneficios muestra:

- los procedimientos dentales cubiertos por el Plan
- el copago por cada procedimiento, el cual Usted es responsable de pagar a Su Dentista Principal o Dentista de Cuidado Especial.

### Costos a Cargo del Asegurado

A fin de mantener el Plan económicamente accesible para Usted y Su Grupo, el Plan incluye ciertas características de partición de gastos. Primero, no todos los procedimientos dentales están cubiertos por Su Plan. Si el procedimiento no está listado en la Lista de Beneficios, no está cubierto. Usted será responsable de pagarle a Su dentista el cargo total por los servicios no cubiertos.

Ciertos procedimientos listados en la Lista de Beneficios requieren Su Copago. Los Copagos están listados en la columna derecha de la Lista. Usted es responsable por pagar los Copagos al momento del servicio a menos que Usted haya hecho otros arreglos con el consultorio dental. Los Copagos son los mismos si el servicio es provisto por Su Dentista Principal o por un Dentista de Cuidado Especial por medio de remisión. Los servicios listados en la Lista de Beneficios con un "0" ó "N/C" en la columna no requieren Su Copago.

Los servicios listados en la Lista de Beneficios también están sujetos a Exclusiones y Limitaciones. Asegúrese de revisar la Lista de Beneficios anexa a este Comprobante de Cobertura.

#### Otros cargos

Usted es responsable de los cargos según se indican en la Lista de Beneficios. Los servicios que no están indicados en la Lista de Beneficios no están cubiertos y son Su responsabilidad.

*IMPORTANTE: Si Usted elige recibir servicios dentales que no son Servicios Cubiertos en virtud de este Plan, es posible que un Dentista Dentro de la Red le cobre su tarifa usual y acostumbrada por dichos servicios. Antes de proporcionar a un Afiliado los servicios dentales que no son un Servicio Cubierto, el dentista debe otorgar al Afiliado un plan de tratamiento que incluya cada servicio que se prevé brindar y el costo estimado de cada servicio. Si Usted desea obtener más información sobre las opciones de cobertura dental, puede llamar a nuestro Departamento de Servicio al Cliente al 866-357-3304 o a Su agente de seguro. Para comprender en su totalidad Su cobertura, se recomienda que revise atentamente este Certificado de Cobertura.*

### Servicios Dentales

Esta sección provee una breve descripción de los tipos de servicios más comunes provistos por dentistas. Si un servicio está listado abajo no significa es un servicio cubierto por Su Plan especifico. Esta lista no es completa. Debe revisar su Lista de Beneficios y Lista de Exclusiones y Limitaciones para determinar Sus Servicios de Cobertura.

Exámenes y diagnósticos: inspección de la parte interna de la boca por un dentista para identificar cualquier enfermedad que necesite tratamiento.

Radiografías para diagnóstico: el tipo y cantidad de radiografías tomadas por el dentista para identificar cualquier enfermedad que necesite tratamiento.

- Radiografías de aleta de mordida radiografías para revisión de la dentadura superior e inferior, generalmente aisladas únicamente a las piezas dentales posteriores, que se le toman al paciente mientras muerde.
- Radiografías panorámicas o de boca completa radiografías que se toman del hueso y los dientes de los maxilares superior e inferior completos, para identificar cualquier enfermedad que necesite tratamiento.

Profilaxis Rutinario: limpieza y pulido estándar de los dientes.

Mantenimiento Periodontal: limpieza "profunda" hecha en visitas de revisión después de tratamiento periodontal.

Sellantes: capa plástica colocada en las áreas de mordida de los dientes traseros para ayudar a prevenir que se forme la caries.

Tratamiento de fluoruro: un químico altamente concentrado colocado en los dientes para hacerlos resistentes a la caries.

Tratamiento Paliativo: procedimientos para aliviar el dolor.

Mantenedores de Espacio: dispositivos de metal y/o acrílico usados para prevenir el movimiento de los dientes.

Restauraciones Básicas: procedimientos que se usan para tratar la caries (cavidades, caries) – por ejemplo, amalgamas, rellenos de resina, coronas de acero inoxidable, fortalecimiento de coronas y postes y núcleos.

Endodoncia: trata la pulpa dental, la cámara pulpar y el conducto de la raíz – tratamiento de conducto y retratamiento de endodoncia, pulpotomía, terapia pulpar, apicectomía y apexificación.

- Terapia de pulpa: un tipo de endodoncia hecha en dientes primarios.

Terapia Periodontal No Quirúrgica: para el tratamiento no quirúrgico de enfermedades de las encías y hueso de inserción de los dientes – curetaje y pulido radicular, mantenimiento periodontal

Curetaje y pulido radicular: una "limpieza profunda" para eliminar el sarro de las raíces de los dientes, que generalmente se hace en varias citas y mediante anestesia local.

Extracciones Simples: extracción no quirúrgica de piezas dentarias y raíces

Terapia Periodontal Quirúrgica: cirugía hecha para curar la enfermedad periodontal.

- Gingivectomía: extracción del tejido excesivo de las encías
- Cirugía ósea: cirugía de encías para tratar enfermedades de la encía y pérdida de hueso

Coronas, Incrustaciones Intracoronarias y Extracoronarias (Inlays y Onlays):

- Incrustación Intracoronaria (Inlay): un relleno dental que está hecho de una impresión del diente, en un laboratorio, y pegado en el diente.
- Incrustación Extracoronaria (Onlay): un tipo de corona preservante que cubre la superficie de oclusión de los

dientes pero solo cubre parcialmente los lados del diente.
- Corona: una tapa que usualmente cubre completamente la superficie exterior de los dientes.

Prótesis:

- Puentes fijos: un dispositivo que remplaza uno o mas dientes faltantes siendo pegado o colocado entre los dientes de soporte que están juntos a (los) diente(s) faltante(s).
- Prótesis removible parcial: un dispositivo removible que remplaza dientes faltantes y colocado entre los dientes restantes en cualquier de las mandibulas la superior o inferior.
- Prótesis removibles completas: un dispositivo removible que reemplaza todos los dientes de la mandíbula superior o inferior.

Ortodoncia:

- para el tratamiento de mala alineación y alteraciones oclusales – radiografías de diagnóstico, tratamiento activo y contención para hijos Dependientes elegibles.

## Exclusiones

Los servicios señalados como cubiertos en la Lista de Beneficios están sujetos a frecuencia o Limitaciones de edad, las cuales se detallan en la Lista adjunta de Exclusiones y Limitaciones. La existencia de una Limitación en la Lista de Exclusiones y Limitaciones no significa que el servicio esté cubierto en el Plan. Antes de examinar las Limitaciones, Usted deberá revisar primero la Lista de Beneficios para ver qué servicios están cubiertos. No se proporcionarán beneficios por servicios, suministros o cargos detallados en las Exclusiones de la Lista de Exclusiones y Limitaciones.

## Tratamiento Alternativo

Todos los diagnósticos y planeamiento de tratamiento son provistos por Su Consultorio Dental Principal. En ocasiones, Usted y Su Consultorio Dental Principal pueden considerar posibles planes de tratamiento alternativo. En esos casos, donde Usted acuerde a un plan de tratamiento alternativo opuesto al Servicio Cubierto, Usted es responsable por el costo adicional del tratamiento alternativo. El costo del tratamiento alternativo será calculado de la diferencia entre el costo usual del proveedor para el tratamiento alternativo y el costo usual del Servicio Cubierto más el copago del Servicio Cubierto.

El Consultorio Dental Principal debe dialogar y proveer los costos y recibir Su autorización del tratamiento alternativo, por escrito, antes que los servicios sean realizados.

## Pago de Beneficios

Pagaremos por beneficios cubiertos directamente a Su Consultorio Dental Principal o el Dentista Especialista. El pago a Dentistas Dentro de Red se basa en las cuotas máximas contratadas.

Todos los contratos entre la Compañía y el Dentista Dentro de la Red dice que bajo ninguna circunstancia el Afiliado es responsable por alguna cantidad debida por la Compañía al dentista. En cualquier situación donde la Compañía incumple o se niega a pagar al dentista, tal disputa es únicamente entre el dentista y la Compañía. El Afiliado no es responsable por cualquier dinero que la Compañía incumple o se niega a pagar.

La Compañía retiene archivos de reclamos y elegibilidad requeridos por la ley federal y estatal. La Compañía cuenta con salvaguardias físicas, electrónicas y procesales para proteger la información de reclamaciones y elegibilidad contra el acceso, uso y divulgación no autorizados.

## Coordinación de Beneficios (COB)

Si Usted o Sus Dependientes están cubiertos por algún otro plan dental y reciben un servicio cubierto por este Plan y por el Otro Plan Dental, los beneficios serán coordinados. Esto significa que un plan será el Plan de Beneficio Dental Primario y determina sus beneficios antes que los del otro plan, y sin considerar los beneficios del otro plan. El otro plan será el Plan de Beneficio Dental Secundario y determina sus beneficios después del Plan de Beneficio Dental Primario. Los beneficios del Plan de Beneficio Dental Secundario pueden reducirse debido al pago del Plan de Beneficio Dental Primario. Cada plan proveerá sólo aquella parte de su beneficio que se requiere para cubrir los gastos para prevenir pagos duplicados y sobrepagos. Al determinarse la responsabilidad primaria o secundaria, Este Plan determinará el pago. Si Este Plan es el Plan de Beneficio Dental Secundario, el pago durante el Período de Determinación de la Reclamación no excederá el total de la cantidad Permitida.

1. Las siguientes palabras y frases referentes a la cláusula de Coordinación de Beneficios ("COB") se definen como se indica a continuación:

   A) **La Cantidad Permitida** es la asignación del Plan para partidas de gastos, cuando la atención dental está cubierta al menos en parte por uno o varios Planes que cubren al Afiliado para quien se hace la reclamación. Cuando un plan provee beneficios en la forma de servicios, en vez de pagos en efectivo, el valor del dinero razonable de cada servicio prestado será considerado como ambos una Cantidad Permitida y un beneficio pagado.
   B) **Período de Determinación de la Reclamación** significa un año de beneficios. Sin embargo, esto no incluye ninguna parte de un año durante el cual una persona no tiene ninguna cobertura bajo este Plan.
   C) **Otro Plan Dental** es cualquier forma de cobertura independiente de este Plan, con la cual se permite la coordinación. **Otro Plan Dental** será cualquiera de los siguientes que proporcionan beneficios dentales, o servicios, para lo siguiente: Medicare, seguro colectivo o cobertura de tipo colectivo, sean asegurados o no asegurados. También incluye cobertura aparte de la cobertura del tipo para accidente escolar (que incluye coberturas para estudiantes de escuelas primaria, secundaria y de universidad) sólo por accidentes, incluyendo lesiones deportivas, sobre una base de veinticuatro (24) horas o sobre una base de "ida y vuelta de la escuela," o colectiva o del tipo colectivo para beneficios de indemnización hospitalaria de $100 por día o menos.
   D) **Plan de Beneficio Dental Primario** es el plan que proporciona la cobertura dental primaria y determina primero sus beneficios y sin considerar los beneficios del otro plan. Es posible que un plan que no incluya la cláusula COB no tome en cuenta los beneficios de otro plan cuando determine sus beneficios.
   E) **Plan de Beneficio Dental Secundario** es el plan que proporciona la cobertura dental secundaria y determina sus beneficios después que los del otro plan (Plan de Beneficio Dental Primario). Los beneficios pueden reducirse debido a los beneficios del otro plan (Plan de Beneficio Dental Primario).
   F) **Este Plan** significa este documento, el cual incluye todas las listas y todas las cláusulas adicionales incorporadas al mismo, y provee beneficios de atención dental para los cuales se aplica esta cláusula COB y que pueden ser reducidos a consecuencia de los beneficios de otros planes dentales.

G) **Plan** se refiere al Plan de Beneficio Dental Primario o al Plan de Beneficio Dental Secundario.

2. El valor justo en efectivo de los servicios proporcionados por la Compañía se considerará como la cantidad de beneficios pagados por la Compañía. La Compañía será totalmente relevada de responsabilidad en la medida del pago bajo esta cláusula.

   A) Como Plan de Beneficio Dental Primario, la compañía pagará la cantidad máxima requerida por Su Póliza de Seguro Colectivo al coordinar sus beneficios con un Plan de Beneficio Dental Secundario.

   B) Como el Plan de Beneficio Dental Secundario, la Compañía pagará lo que resulte menor, sea la cantidad que se hubiera pagado en ausencia de cobertura de cualquier otro beneficio dental o el costo de desembolso total del Afiliado pagadero conforme al Plan de Beneficio Dental Primario, para los beneficios cubiertos según el Plan de Beneficio Dental Secundario.

3. A fin de determinar qué Plan es Primario, Este Plan utilizará las siguientes reglas:

   A) Si el Otro Plan Dental no tiene una provisión similar a esta, entonces ese Plan será el primario y aplica esta regla de Coordinación de Beneficios de este Plan.
   B) Si ambos planes tienen cláusulas COB, el plan que cubre al Afiliado como asegurado primario se determinará antes de aquellas del plan que cubre a la persona como Dependiente.
   C) Hijo Dependiente/Padres Ni Separados Ni Divorciados - Las reglas para el orden de beneficios para un hijo Dependiente cuando los padres no están ni separados ni divorciados, son:
      1) Los beneficios del plan del padre cuyo cumpleaños caiga primero en el año son determinados antes de aquellos del plan del padre cuyo cumpleaños caiga más tarde en ese año;
      2) Si ambos padres cumplen años el mismo día, los beneficios del plan que han cubierto al padre durante más tiempo son determinados antes de aquellos del plan que ha cubierto al otro padre durante un período de tiempo más corto;
      3) La palabra "cumpleaños" se refiere sólo al mes y día de un año calendario, no al año en el cual nació la persona;
      4) Si el otro Plan no sigue la regla del cumpleaños, pero en cambio tiene una regla basada en el sexo del padre/madre; y si, por consiguiente, los planes no coinciden con el orden de beneficios, la regla basada en el sexo del padre/madre determinará el orden de beneficios.
   D) Hijo Dependiente/Padres Separados o Divorciados - Si dos o más planes cubren a una persona como hijo Dependiente de padres divorciados o separados, los beneficios para el hijo serán determinados en este orden:
      1) Primero, el plan del padre que tiene la custodia del hijo.
      2) Después, el plan del cónyuge del padre que tiene la custodia del hijo; y
      3) finalmente, el plan del padre que no tiene la custodia del hijo.
      4) Si los términos específicos de un decreto de tribunal declaran que uno de los padres es responsable de los gastos de la atención dental del hijo, y la entidad obligada a pagar o proporcionar los beneficios del plan de ese padre tiene conocimiento de dichos términos, los beneficios de ese plan se determinarán en primer lugar. El plan del otro padre será el Plan Secundario.
      5) Si los términos específicos del decreto del tribunal declaran que los padres compartirán la custodia conjuntamente, sin declarar que uno de los padres es responsable de los gastos del cuidado dental del hijo, los planes que cubren al hijo seguirán el orden de las reglas de determinación de beneficios

descritos en la Sección 3-C) de arriba, titulada Hijo Dependiente/Padres Ni Separados Ni Divorciados.

E) Afiliado Activo/Inactivo
   1) El plan será primario para los Afiliados empleados activamente que sean mayores de 65 años de edad y estén cubiertos por Medicare y para sus cónyuges.
   2) Cuando un contrato es un plan de jubilación y el otro es un plan activo, el plan activo será primario. Un plan de jubilación se refiere a un plan que cubre a un empleado pensionado o un Dependiente de un empleado. Un plan activo se refiere a un plan que cubre a una persona como empleado o Dependiente de un empleado. Cuando dos planes de jubilación están implicados, el que haya estado vigente durante más tiempo será primario. Cuando el plan está bajo el plan de jubilación y el otro plan es para el empleado desempleado, el plan del empleado desempleado es el principal. Si otro contrato no tiene esta regla en la cual resultan que cada plan determina los beneficios de otro, entonces esta regla debe ser ignorada.

F) El plan que cubra a una persona, como la continuidad por Cal-COBRA, será secundario al plan que cubra a esa persona como Suscriptor o un Afiliado. Si otro plan no tiene esta regla en la cual resultan que cada plan determina los beneficios de otro, entonces esta regla debe ser ignorada.

G) Si ninguna de estas reglas se aplica, entonces el contrato que ha cubierto continuamente al Afiliado por el cual hizo el reclamo durante un período de tiempo más largo, será primario.

4. Derecho de Recibir y Divulgar Información Necesaria -- Ciertos hechos son necesarios para aplicar estas reglas de COB. La Compañía tiene el derecho de decidir qué hechos necesita. Podrá conseguir o proporcionar hechos necesarios de/a cualquier otra organización o persona. Cualquier información de salud entregada a un tercero será liberada de acuerdo con la ley estatal y federal. Toda persona que reclame beneficios bajo Este Plan deberá proporcionar cualquier hecho necesario para que se le pague la reclamación.

5. Facilidades de Pago -- Un pago hecho bajo otro plan puede incluir una cantidad que debió haber sido pagada bajo Este Plan. Si se hace esto, la Compañía puede pagar la cantidad a la organización que hizo ese pago. Esta cantidad será, entonces, tratada como si fuera un beneficio pagado bajo Este Plan, y la Compañía no pagará esa cantidad otra vez. El término "pago hecho" incluye la prestación de beneficios en forma de servicios, en cuyo caso el "pago hecho" significa el valor razonable en efectivo de los beneficios provistos en forma de servicios pagados por adelantado por la Compañía.

6. Derecho de Recuperación - Si el pago hecho por la Compañía es superior al que debería haber pagado bajo esta cláusula COB, la Compañía puede recuperar el excedente de una o varias de las siguientes maneras: (1) personas a las que ha pagado o por quienes se ha pagado; o (2) compañías de seguros; o (3) otra organización. Se requiere que los Afiliados asistan a la Compañía para implementar esta sección.

## Compensación de los Trabajadores

Cuando un Afiliado es elegible para los beneficios de Compensación de los Trabajadores a través del empleo, el costo del tratamiento dental por una lesión que surge de y en el curso del empleo del Afiliado, no es un beneficio que esté cubierto por este Plan. Por lo tanto, si la Compañía paga beneficios que estén cubiertos por un contrato de Compensación de los Trabajadores, la Compañía tiene el derecho de obtener el reembolso de los beneficios pagados. El Afiliado deberá proporcionar cualquier ayuda necesaria, incluyendo la entrega de información y firma de documentos necesarios, para que la Compañía reciba el reembolso.

## Revisión de una Determinación de Beneficios

Si Usted no está satisfecho con la administración del beneficio de Su Plan, por favor póngase en contacto con Nuestro Departamento de Servicio al Cliente al número telefónico gratuito que aparece en la sección de Introducción de este Comprobante de Cobertura. Si después de hablar con un representante de Servicio al Cliente, Usted todavía se siente descontento, consulte el Procedimiento de Segunda Opinión y Procedimiento de Apelación de Disputa para conocer los pasos adicionales que puede Usted tomar con respecto a Su reclamación.

## Segunda Opinión

Usted o Su Dentista Dentro de la Red puede solicitar una segunda opinión. La petición de segunda opinión puede ser hecha llamando o por escrito al Servicio Dental al Cliente en la dirección o número telefónico a continuación, bajo "Resolución de Queja". Las razones para una segunda opinión incluyen, entre otras, las siguientes:

1. Si el Afiliado tiene preguntas de la razón o necesidad de los procedimientos quirúrgicos recomendados;
2. Si el Afiliado tiene preguntas sobre un diagnóstico o plan de cuidado para una condición que amenaza la vida, pérdida de extremidad, pérdida de función corporal o impedimento sustancial, incluyendo, entre otras, una condición crónica grave;
3. Si los indicadores clínicos no están claros o son complejos y confusos, está en duda un diagnóstico a causa de los resultados conflictivos de un examen, o el profesional de salud que atiende no puede diagnosticar la condición, y el Afiliado solicita un diagnóstico adicional;
4. Si el plan tratamiento en progreso no está mejorando la condición dental del Afiliado durante un periodo apropiado considerando el diagnostico y el plan de cuidado, y el Afiliado solicita una segunda opinión referente al diagnostico o continuación del tratamiento; o
5. Si el Afiliado ha intentado seguir el plan de cuidado o consultado con el proveedor inicial sobre preocupaciones serias acerca del diagnostico o plan de cuidado.

La autorización o negación de una petición de segunda opinión se hará de una forma apresurada. Cuando la condición del Afiliado el tal que el Afiliado enfrenta una amenaza inminente y seria a Su salud, incluyendo, pero no limitada a, la posible perdida de la vida, extremidad u otra función mayor del cuerpo, o la falta de puntualidad que será dañina a la habilidad del Afiliado para recuperar la función máxima, la decisión para la autorización o negación para una segunda opinión será proporcionada en forma puntual adecuada para la naturaleza de la condición, sin exceder 72 horas de la recepción de la petición, cuando es posible. Estas normas escritas referentes a la puntualidad para responder a peticiones de segunda opinión están disponibles a los Afiliados del Plan bajo petición.

El costo de una segunda opinión autorizada será la responsabilidad del Plan, menos cualquier Copago del paciente aplicable a pagar por el Afiliado en el momento del servicio. Las segundas opiniones no autorizadas son la responsabilidad financiera exclusiva del Afiliado.

Una segunda opinión autorizada será provista por un proveedor de la elección del Afiliado contratado y capacitado adecuadamente. Si no está razonablemente disponible otro proveedor del Plan quien cumple estas normas, entonces el Plan autorizará una segunda opinión fuera de la red. Las segundas opiniones no son cubiertas con proveedores fuera de la red sin la previa autorización del Plan.

Si el Plan niega la petición para una segunda opinión, el Afiliado puede presentar una queja siguiendo el Procedimiento de Resolución de Queja.

## PROCEDIMIENTO DE RESOLUCIÓN DE QUEJA

Cualquier Afiliado que esté insatisfecho con cualquier aspecto de United Concordia puede presentar por escrito Su queja o denuncia. Aunque United Concordia prefiere que la queja o denuncia la presente el Afiliado por escrito debido a la naturaleza más concisa de las declaraciones escritas en comparación con las declaraciones verbales, las quejas o denuncias también pueden ser presentadas verbalmente con la ayuda de un representante de United Concordia. La ayuda para presentar una queja o denuncia se proporciona, según sea necesario, en cada lugar donde se reciben quejas o denuncias. El Afiliado, o quien actúe en Su representación, deberá presentar la queja o denuncia en un plazo no mayor de 180 días, contados a partir del (o los) incidente(s) o acto(s) que fue (o fueron) el motivo de la insatisfacción del afiliado. La queja o denuncia debe contener detalles suficientes para identificar la naturaleza del problema.

Se debe enviar una carta o Informe de Disconformidad con United Concordia, debidamente llenado, al Departamento de Servicios al Cliente (Customer Services Department) en: P.O. Box 10194, Van Nuys, CA 91410-0194, o mediante el sitio Web de United Concordia www.unitedconcordia.com, o también puede llamar a Servicio al Cliente, marcando 866-357-3304, para solicitar asistencia.

El Afiliado que presente una queja o denuncia no será objeto de discriminación, ni baja ni otras sanciones, por el hecho de presentar una queja.

Los formularios de Queja o de Denuncia, así como una descripción del procedimiento de queja o denuncia, están a su disposición directamente en United Concordia, en el sitio Web de United Concordia www.unitedconcordia.com, y en las instalaciones de cada proveedor contratado, donde se los entregarán con solo pedirlos.

Acusaremos el recibo de Su queja en el plazo de cinco (5) días. Después de recibirla, nos comunicaremos con las partes interesadas y recopilaremos todos los hechos, registros dentales y otros documentos de soporte pertinentes. **Se enviará una copia de su queja al (o los) consultorio(s) dental/es que es (o son) el tema de su queja.**

Las quejas o denuncias se resolverán en el término de 30 días. Se le enviará al afiliado un aviso de la resolución de la –queja o denuncia dentro de los 30 días siguientes a la recepción de dicha queja o denuncia.

El Afiliado puede presentar una queja o denuncia ante el Departamento de Administración del Cuidado de la Salud (DMHC, por sus siglas en inglés) si no recibe una respuesta de United Concordia en 30 días o tan pronto como reciba una decisión por escrito, o en cualquier momento si el DMHC determina que el asunto implica una amenaza inminente y grave para la salud del paciente, como dolor intenso, posible pérdida de la vida, alguna extremidad o función corporal, entre otras cosas, o en cualquier caso en que el DMHC determine que es necesaria una revisión previa.

Debido a las regulaciones concernientes a la confidencialidad de los expedientes médicos de paciente, toda resolución de una queja o denuncia le será enviada únicamente al Consultorio Dental y al Afiliado. Esas respuestas se harán por escrito y serán enviadas con la más estricta confidencialidad.

Si los Afiliados no dominan el inglés, tienen problemas de la vista o el oído, o están limitados de cualquier otra forma, de modo que se les dificulte acceder al sistema de quejas y denunciasde United Concordia, United Concordia les proporcionará la asistencia necesaria.

El sistema de quejas o denuncias de United Concordia atiende las necesidades lingüísticas y culturales de sus Afiliados, así como las necesidades de sus Afiliados con discapacidades, a fin de asegurar que todos tengan acceso al sistema de quejas y denuncias y puedan participar plenamente, de las siguientes maneras:

1. Traducciones de los procedimientos y formularios de quejas o denuncias y las respuestas del plan a las quejas o denuncias, según sea necesario.
2. Acceso a intérpretes por teléfono,
3. Acceso a sistemas de retransmisión telefónica y otros dispositivos que ayudan a las personas discapacitadas a comunicarse.
4. Otras formas de asistencia personalizada para satisfacer las necesidades específicas del Afiliado.

Puede acceder a los servicios anteriormente referidos poniéndose en contacto con Servicio al Cliente en el teléfono 866-357-3304.

En caso de presentarse una queja o denuncia urgente relacionada con un riesgo inminente o grave para la salud del paciente, incluyendo, entre otros, dolor intenso, posible pérdida de la vida, una extremidad o una función corporal mayor, United Concordia llevará a cabo una revisión expedita de la queja o denuncia. Una vez que United Concordia tome conocimiento de revisión expedita, United Concordia informará de inmediato al Afiliado sobre sus derecho y el mecanismo para informar la queja o denuncia al DMHC. Asimismo, United Concordia notificará al afiliado sobre la resolución o el estado de avance de una queja o denuncia urgente en menos de tres (3) días a partir de la fecha de recepción de dicha queja o denuncia.

Debido a la limitaciones reglamentarias del tiempo para resolver una queja o denuncia, **no es posible** apelar ante United Concordia la resolución de dicha queja o denuncia.

**"El Departamento de Administración de Cuidado de Salud de California es responsable de regular los planes de servicios de atención médica. Si Usted tiene quejas en contra de Su plan de salud, debe llamar primero a Su plan de salud al 866-357-3304 y usar el proceso de quejas de Su plan antes de comunicarse con el departamento. La utilización del proceso de queja no prohíbe cualesquier posibles derechos legales o remedios que puedan estar disponibles a Usted. Si necesita ayuda con una queja que incluye una emergencia, una queja que no ha sido resuelta satisfactoriamente por el plan de salud, o una queja que ha permanecido sin resolver por más de 30 días, Usted puede llamar al departamento por asistencia. Usted también puede tener derecho a una Revisión Médica Independiente (IMR, por sus siglas en inglés). Si Usted tiene derecho a una IMR, el proceso de IMR proveerá una revisión imparcial de las decisiones médicas hechas por un plan de salud relacionado a la necesidad médica de un servicio o tratamiento propuesto, decisiones de cobertura para tratamientos que son de naturaleza experimental o de investigación y disputas de pago por servicios médicos urgentes o de emergencia. El departamento también tiene un número de teléfono gratuito (1-888-HMO-2219) y una línea TDD (1-877-688-9891) para personas con impedimentos del habla o auditivos. El sitio Web del departamento, http://www.hmohelp.ca.gov, cuenta con formularios de queja, formularios de solicitud de IMR e instrucciones en línea."**

## PROVISIONES DE RENOVACIÓN

Al concluir el término original, este Comprobante de Cobertura será renovado automáticamente de manera anual como está provisto en el Contrato Colectivo. A Su petición la Compañía le proveerá una copia del Contrato Colectivo.

## DERECHO DE CANCELACIÓN Y RESTRICCIONES DE RENOVACIÓN

El Plan también puede ser cancelado o terminado en cualquier momento basándose en la Sección de Terminación de Beneficios.

## TERMINACIÓN DE BENEFICIOS

Su cobertura y/o la cobertura de Sus Dependientes terminarán a las 12:01 AM PST:

- en la fecha en que Usted pierde la elegibilidad conforme a los requisitos de elegibilidad de Su Grupo; o
- en la fecha en que cesa el pago de la Prima para Usted y/o Sus Dependientes, como lo especifica Su Grupo; o
- en la fecha en que Su(s) Dependiente(s) dejen de llenar los requisitos que se señalan en la definición de Dependiente que se encuentra en la sección de Definiciones de este Comprobante de Cobertura.
- en la fecha de matasellos postal le proveemos aviso de una disposición final de una convicción de fraude Suya o de Sus Dependientes; o
- en la fecha de un cambio de la residencia del Suscriptor a un área fuera del Estado de California. La cobertura debe continuar para Dependientes que residen en California con un padre sin custodia.

Si Su cobertura o la cobertura de Sus Dependientes termina debido a lo que se describe arriba, la cobertura para completar un procedimiento dental que requiera dos o más visitas en días separados será ampliada por un período de 90 días posteriores a la Fecha de Terminación del Afiliado, a fin de que el procedimiento pueda finalizarse. El procedimiento debe comenzarse antes de la Fecha de Terminación del Afiliado. El proceso es considerado "iniciado" cuando el procedimiento no puede ser cambiado o inverso. Por ejemplo, para coronas, puentes y prótesis removibles, el procedimiento comienza cuando las piezas dentarias están preparadas y se han tomado las impresiones. Para tratamientos de endodoncia, el procedimiento comienza cuando se abre el diente y se extrae la pulpa. Para el tratamiento de ortodoncia, de estar cubierto por el Plan, la cobertura se ampliará hasta el final del mes de la Fecha de Terminación del Afiliado.

La Compañía no está obligada a pagar ningún beneficio por servicios que se realicen después de la Fecha de Terminación de la cobertura de un Afiliado o del Contrato Colectivo.

La cobertura debe permanecer en efecto por 31 días después de la fecha de vencimiento de la prima. Si la prima no es recibida dentro del Período de Gracia, la cobertura será cancelada inmediatamente en el primer día siguiente del vencimiento del Período de Gracia. El Asegurado es responsable por la Prima acumulada durante el Período de Gracia.

Si un Afiliado alega que este Comprobante de Cobertura no fue renovado o terminado debido al estado de salud de un familiar del Afiliado o Suscriptor, puede solicitar una revisión de la cancelación por parte del Director—del Departamento de la Administración de Cuidado de Salud.

## COBRA FEDERAL

La ley federal puede exigir que ciertos empleadores ofrezcan una continuación de cobertura a los Afiliados durante un período específico de tiempo, luego de la terminación del empleo o reducción de horas de trabajo por cualquier razón que no sea por falta grave. Usted deberá ponerse en contacto con Su empleador para averiguar si este requisito se aplica a Usted y a Su empleador. Su empleador le informará a Usted sobre Sus derechos a la continuación de cobertura y el costo de la misma. Si este requisito se aplica, Usted

debe elegir continuar con la cobertura en un plazo de 60 días a partir de Su evento calificador, o notificación de derechos de parte de Su empleador, lo que suceda en segundo lugar. Usted puede optar por ampliar la cobertura de Su(s) Dependiente(s), o el (o los) Dependiente(s) pueden optar por continuar la cobertura en ciertas circunstancias o eventos calificadores. El (los) Dependiente(s) deberá(n) elegir continuar con la cobertura en un plazo de 60 días a partir de Su evento o notificación de derechos de parte de Su empleador, lo que suceda en segundo lugar. Usted deberá pagar la prima requerida de la cobertura continua directamente a Su empleador. La Compañía no es responsable de determinar quién es elegible para la cobertura continua.

## CLÁUSULAS GENERALES

Este Comprobante de Cobertura incluye e incorpora cualquiera y todas las cláusulas adicionales, endosos, anexos y listas, y junto con la Contrato Colectivo representa el acuerdo total entre las partes con respecto al asunto de que se trate. La omisión de cualquier sección o inciso de este Comprobante de Cobertura no afectará la validez, legalidad y aplicabilidad de las secciones restantes.

La Compañía puede asignar este Comprobante de Cobertura, con la aprobación del Departamento de la Administración de Cuidado de Salud (o sus sucesores) y sus derechos y obligaciones en la presente a cualquier entidad bajo control común de la Compañía.

Este Comprobante de Cobertura será entendido para todos los objetivos como un documento legal y será interpretado y hecho cumplir de acuerdo con las leyes pertinentes y las regulaciones del Estado de California.

### Confidencialidad de Archivos Dentales

**Está disponible una declaración describiendo nuestras políticas y procedimientos para preservar la confidencialidad de los archivos dentales y se le será proporcionada a Su petición.**

### Derechos de la Compañía para Cambiar el Plan

Salvo que se contemplara aquí de otra forma, este Comprobante de Cobertura puede ser enmendado, cambiado o modificado solo por escrito y, después de eso, anexado como parte de este Comprobante de Cobertura.

### Sugerencias y Comentarios

La Compañía acoge con agrado las sugerencias y comentarios para mejorar el servicio de este Plan. Los Afiliados pueden enviar preguntas y comentarios al Comité de Política Pública de la Compañía. El Comité de Política Pública establece y revisa la política pública del Plan. El Comité consiste en representantes de por lo menos un 51% de Afiliados Cubiertos bajo este Plan. Si Usted desea ser considerado para la selección del Comité, presente Sus credenciales por escrito a la dirección en la portada de este Comprobante de Cobertura. El Plan revisa la membresía del Comité de manera anual. El Plan le notificará de Su decisión de selección después de la revisión anual.

## INFORMACIÓN SOBRE LA CONTINUIDAD DE LA ATENCIÓN DEL NUEVO AFILIADO

Continuidad de la Atención:

Si ha sido atendido por un proveedor de atención dental, Usted puede tener derecho a mantener ese mismo proveedor de atención dental por un período determinado. Póngase en contacto con el departamento de servicio al cliente de este Plan al 1-866-357-3304, y si tiene más preguntas, contacte al Departamento de Administración del Cuidado de la Salud, organismo responsable de la protección de los consumidores HMO, al teléfono gratuito 1-888-HMO-2219; si tiene alguna discapacidad auditiva, llame al número TDD 1-877-688-9891, o visite su sitio web en www.hmohelp.ca.gov. También puede solicitar una copia de nuestra póliza de continuidad de la atención en nuestro departamento de servicio al cliente. Esta póliza no aplica a los afiliados de cobertura reciente con un acuerdo de suscriptor individual.

Usted debe hacer una solicitud específica para continuar bajo el cuidado de Su proveedor actual. No estamos obligados a continuar Su atención con ese proveedor si Usted no es elegible conforme nuestra póliza o si no podemos llegar a un acuerdo con Su proveedor en los términos referentes a Su atención, según la ley de California.

**FEDERAL LAW SUPPLEMENT**

**TO**

**CERTIFICATE OF INSURANCE**

This Supplement amends your Certificate by adding the following provisions regarding special enrollment periods and extended coverage requirements currently mandated or that may be mandated in the future under federal law.

You may enroll for dental coverage at any time for yourself and your dependents if:

(1) You or your dependent either loses eligibility for coverage under Medicaid or the Children's Health Insurance Program ("CHIP"); or

(2) You or your dependent becomes eligible for premium assistance from Medicaid or CHIP allowing enrollment in a benefit program.

In order to enroll, you must submit complete enrollment information to your group or its plan administrator within sixty (60) days from your or your dependent's loss of coverage or eligibility for premium assistance, as the case may be.

Other special enrollment periods and rights may apply to you or your dependents under new or existing federal laws. Consult your group, its plan administrator or your group's summary plan description for information about any new or additional special enrollment periods, enrollment rights or extended coverage periods for dependents mandated under federal law.

# UNITED CONCORDIA

**Concordia Plus**
**Lista de Beneficios**
**Plan CA 946**

## INFORMACIÓN IMPORTANTE SOBRE SU PLAN

- Esta Lista de Beneficios le ofrece un listado de los procedimientos que cubre Su Plan. Para procedimientos que requieren un Copago, el importe a pagar se muestra en la columna titulada "El Afiliado Paga $". Usted tendrá que pagar estos Copagos en el consultorio dental al momento de la prestación del servicio.
- Para recibir los Servicios Cubiertos, debe seleccionar un Consultorio Dental Primario (Primary Dental Office, PDO) de United Concordia. Su PDO realizará los procedimientos indicados más adelante o lo remitirá a Usted a un Dentista de Atención Especializada para que siga atendiéndole. No está cubierto el tratamiento de un Dentista Fuera de la Red, salvo que esté especificado en el Certificado de Cobertura.
- Los únicos Servicios que están Cubiertos son los procedimientos indicados en esta Lista de Beneficios. En el caso de los servicios no listados (sin cobertura), Usted es responsable de pagar la tarifa completa que cobre el dentista. Los códigos de los procedimientos y los Copagos de los afiliados podrían actualizarse para adaptarlos a la Terminología Dental Actual (Current Dental Terminology, CDT) de la Asociación Dental Estadounidense (American Dental Association, ADA), de acuerdo con los estándares nacionales.
- Los Dentistas Dentro de la Red cobrarán un importe adicional de $125 por el uso de metales preciosos (muy nobles) o semipreciosos (nobles).
- Para obtener una descripción completa de Su Plan, consulte el Certificado de Cobertura, y las Exclusiones y Limitaciones, además de esta Lista de Beneficios.
- Si tiene alguna pregunta acerca de Su Plan Dental de United Concordia, llame sin costo a nuestro Departamento de Servicio al Cliente, al **1-866-357-3304**, o visite nuestro Sitio Web en **www.unitedconcordia.com**.

| CÓDIGO ADA | DESCRIPCIÓN DE LA ADA | El afiliado Paga $ |
|---|---|---|
| | **EVALUACIONES BUCALES CLÍNICAS** | |
| D0120 | Evaluación bucal periódica - paciente habitual | 0 |
| D0140 | Evaluación bucal limitada - problema específico | 0 |
| D0145 | Evaluación bucal de un paciente menor de 3 años de edad y consulta de orientación con su cuidador primario | 0 |
| D0150 | Evaluación bucal integral - paciente nuevo o habitual | 0 |
| D0160 | Evaluación bucal completa y exhaustiva - problema específico, por informe | 0 |
| D0170 | Reevaluación - limitada, problema específico (paciente habitual, no es una consulta posoperatoria) | 0 |
| D0180 | Evaluación periodontal integral - paciente nuevo o habitual | 0 |
| | **RADIOGRAFÍAS/IMÁGENES DIAGNÓSTICAS** | |
| | **(incluye interpretación)** | |
| D0210 | Intraoral - serie completa (incluye radiografías de aleta de mordida) | 0 |
| D0220 | Intraoral - primera radiografía periapical | 0 |
| D0230 | Intraoral - cada radiografía periapical adicional | 0 |
| D0240 | Intraoral - radiografía oclusal | 0 |
| D0250 | Extraoral - primera radiografía | 0 |
| D0260 | Extraoral - cada radiografía adicional | 0 |
| D0270 | Radiografía de aleta de mordida - una radiografía | 0 |
| D0272 | Radiografías de aleta de mordida - dos radiografías | 0 |
| D0273 | Radiografías de aleta de mordida - tres radiografías | 0 |
| D0274 | Radiografías de aleta de mordida - cuatro radiografías | 0 |
| D0277 | Radiografías de aleta de mordida verticales - entre 7 y 8 radiografías | 0 |
| D0330 | Radiografía panorámica | 0 |
| D0340 | Radiografía cefalométrica | 0 |
| D0350 | Imágenes fotográficas bucofaciales | 15 |
| | **PRUEBAS Y EXÁMENES** | |
| D0415 | Toma de muestras de microorganismos para cultivo y pruebas de sensibilidad | 0 |
| D0416 | Cultivo viral | 0 |
| D0417 | Toma y preparación de muestras de saliva para pruebas de diagnóstico en laboratorio | 30 |
| D0418 | Análisis de muestra de saliva | 25 |
| D0421 | Prueba genética de susceptibilidad a la enfermedad bucal | 0 |
| D0425 | Pruebas de susceptibilidad a las caries | 0 |
| D0431 | Pruebas complementarias de diagnóstico previo para facilitar la detección de anormalidades en la mucosa, incluyendo lesiones premalignas y malignas; se excluyen los procedimientos citológicos o las biopsias | 0 |
| D0460 | Pruebas de vitalidad pulpar | 0 |
| D0470 | Moldes para diagnóstico | 0 |
| | **LABORATORIO DE PATOLOGÍA ORAL** | |
| D0472 | Obtención del tejido, examen visual, y elaboración y envío del informe por escrito | 35 |
| D0473 | Obtención del tejido, examen visual y microscópico, y elaboración y envío del informe por escrito | 55 |
| D0474 | Obtención del tejido, examen visual y microscópico, incluyendo la evaluación de los márgenes quirúrgicos para detectar la enfermedad, y elaboración y envío del informe por escrito | 75 |
| D0502 | Otros procedimientos de patología bucal, por informe | 55 |
| | **PROFILAXIS DENTAL** | |
| D1110 | Profilaxis - adulto | 0 |
| D1120 | Profilaxis - niño | 0 |
| | **TRATAMIENTO TÓPICO CON FLÚOR** | |
| | **(procedimiento en el consultorio)** | |
| D1203 | Aplicación tópica de flúor - niños | 0 |
| D1204 | Aplicación tópica de flúor - adultos | 0 |
| D1206 | Barniz tópico de flúor; aplicación terapéutica para pacientes con riesgo de caries moderado y alto | 0 |
| | **OTROS SERVICIOS PREVENTIVOS** | |
| D1310 | Asesoría nutricional para el control de la enfermedad dental | 0 |
| D1320 | Asesoría sobre consumo de tabaco para el control y la prevención de la enfermedad bucal | 0 |
| D1330 | Instrucciones para la higiene bucal | 0 |
| D1351 | Sellante - por pieza dentaria | 0 |
| | **MANTENIMIENTO DE ESPACIOS** | |
| | **(aparatos pasivos)** | |
| D1510 | Mantenedor de espacio - fijo - unilateral | 55 |
| D1515 | Mantenedor de espacio - fijo - bilateral | 84 |
| D1520 | Mantenedor de espacio - removible - unilateral | 66 |
| D1525 | Mantenedor de espacio - removible - bilateral | 85 |
| D1550 | Recementado del mantenedor de espacio | 0 |
| D1555 | Extracción del mantenedor de espacio fijo | 8 |
| | **RESTAURACIONES DE AMALGAMAS** | |
| | **(incluye el pulido)** | |
| D2140 | Amalgama - una superficie, primaria o permanente | 14 |
| D2150 | Amalgama - dos superficies, primaria o permanente | 15 |
| D2160 | Amalgama - tres superficies, primaria o permanente | 16 |

| CÓDIGO ADA | DESCRIPCIÓN DE LA ADA | El afiliado Paga $ |
|---|---|---|
| D2161 | Amalgama - cuatro o más superficies, primaria o permanente | 20 |
| | **RESTAURACIONES DE COMPUESTOS A BASE DE RESINA - DIRECTA** | |
| D2330 | Compuesto a base de resina - una superficie, anterior | 19 |
| D2331 | Compuesto a base de resina - dos superficies, anterior | 21 |
| D2332 | Compuesto a base de resina - tres superficies, anterior | 25 |
| D2335 | Compuesto a base de resina - cuatro o más superficies o con afectación del ángulo incisivo (anterior) | 31 |
| D2390 | Corona con compuesto a base de resina, anterior | 31 |
| D2391 | Compuesto a base de resina - una superficie, posterior | 85 |
| D2392 | Compuesto a base de resina - dos superficies, posterior | 109 |
| D2393 | Compuesto a base de resina - tres superficies, posterior | 133 |
| D2394 | Compuesto a base de resina - cuatro o más superficies, posterior | 140 |
| | **RESTAURACIONES DE INCRUSTACIONES INTRACORONARIAS (INLAYS) Y EXTRACORONARIA (ONLAYS)** | |
| D2510 | Incrustación intracoronaria (inlay) - metálica - una superficie | 62 ◆ |
| D2520 | Incrustación intracoronaria (inlay) - metálica - dos superficies | 185◆ |
| D2530 | Incrustación intracoronaria (inlay) - metálica - tres o más superficies | 190◆ |
| D2542 | Incrustación extracoronaria (onlay) - metálica - dos superficies | 174◆ |
| D2543 | Incrustación extracoronaria (onlay) - metálica - tres superficies | 195◆ |
| D2544 | Incrustación extracoronaria (onlay) - metálica - cuatro o más superficies | 195◆ |
| | **CORONAS - ÚNICAMENTE PARA RESTAURACIONES SIMPLES** | |
| D2710 | Corona - compuesto a base de resina (indirecto) | 69 |
| D2712 | Corona - compuesto a base de 3/4 de resina (indirecto) | 69 |
| D2720 | Corona - resina con metal muy noble | 237◆ |
| D2721 | Corona - resina con metal base predominante | 210 |
| D2722 | Corona - resina con metal noble | 221◆ |
| D2740 | Corona - sustrato de porcelana/cerámica | 237 |
| D2750 | Corona - porcelana fundida con metal muy noble | 237 |
| D2751 | Corona - porcelana fundida con metal base predominante | 210 |
| D2752 | Corona - porcelana fundida con metal noble | 221 |
| D2780 | Corona - 3/4 de metal muy noble colado | 224◆ |
| D2781 | Corona - 3/4 de metal base predominante colado | 197 |
| D2782 | Corona - 3/4 de metal noble colado | 214 |
| D2783 | Corona - 3/4 de porcelana/cerámica | 237 |
| D2790 | Corona - colado completo de metal muy noble | 224◆ |
| D2791 | Corona - colado completo de metal base predominante | 210 |
| D2792 | Corona - colado completo de metal noble | 214 |
| D2794 | Corona - titanio | 210 |
| D2799 | Corona provisional | 0 |
| | **OTROS SERVICIOS DE RESTAURACIÓN** | |
| D2910 | Recementado de incrustaciones intracoronarias (inlays) o extracoronarias (onlays), o restauración parcial de funda | 21 |
| D2915 | Recementado de postes y núcleos colados o prefabricados | 21 |
| D2920 | Recementado de corona | 21 |
| D2930 | Corona prefabricada de acero inoxidable - pieza dentaria primaria | 53 |
| D2931 | Corona prefabricada de acero inoxidable - pieza dentaria permanente | 57 |
| D2932 | Corona prefabricada de resina | 55 |
| D2933 | Corona prefabricada de acero inoxidable con frente estético de resina | 75 |
| D2934 | Corona prefabricada de acero inoxidable con revestimiento estético - pieza dentaria primaria | 75 |
| D2940 | Empaste paliativo | 0 |
| D2950 | Reconstrucción de muñón, incluye espigas | 15 |
| D2951 | Retención de espiga - por pieza dentaria, además de la restauración | 4 |
| D2952 | Poste y núcleo además de la corona, fabricada indirectamente | 85 |
| D2953 | Cada poste adicional fabricado indirectamente - misma pieza dentaria | 10 |
| D2954 | Poste y núcleo prefabricados, además de la corona | 70 |
| D2955 | Extracción de poste (no se realiza junto con la terapia endodóntica) | 0 |
| D2957 | Cada poste prefabricado adicional - misma pieza dentaria | 10 |
| D2970 | Corona temporal (pieza dentaria fracturada) | 53 |
| D2971 | Tratamientos adicionales para construir nueva corona en la estructura de una prótesis removible parcial existente | 25 |
| D2980 | Reparación de corona, por informe | 25 |
| | **RECUBRIMIENTO PULPAR** | |
| D3110 | Recubrimiento pulpar - directo (no incluye la restauración final) | 0 |
| D3120 | Recubrimiento pulpar - indirecto (no incluye la restauración final) | 0 |
| | **PULPOTOMÍA** | |
| D3220 | Pulpotomía terapéutica (no incluye la restauración final) | 25 |
| D3221 | Desbridamiento pulpar, piezas dentarias primarias y permanentes | 25 |
| D3222 | Pulpotomía parcial para apexogénesis - pieza dentaria permanente con desarrollo incompleto de la raíz | 25 |
| | **TERAPIA ENDODÓNTICA DE PIEZAS DENTARIAS PRIMARIAS** | |
| D3230 | Terapia pulpar (relleno reabsorbible) - pieza dentaria primaria anterior (no incluye la restauración final) | 30 |
| D3240 | Terapia pulpar (relleno reabsorbible) - pieza dentaria primaria posterior (no incluye la restauración final) | 33 |
| | **TERAPIA ENDODÓNTICA (incluye plan de tratamiento, procedimientos clínicos y atención dental de seguimiento)** | |
| D3310 | Terapia endodóntica, pieza dentaria anterior (no incluye restauración final) | 60 |
| D3320 | Terapia endodóntica, pieza dentaria bicúspide (no incluye restauración final) | 75 |
| D3330 | Terapia endodóntica, molar (no incluye restauración final) | 175 |
| | **REPETICIÓN DE TERAPIA ENDODÓNTICA** | |
| D3346 | Repetición de terapia endodóntica previa - anterior | 85 |
| D3347 | Repetición de terapia endodóntica previa - bicúspide | 95 |
| D3348 | Repetición de terapia endodóntica previa - molar | 125 |
| | **TRATAMIENTOS DE APEXIFICACIÓN/RECALCIFICACIÓN** | |
| D3351 | Apexificación/recalcificación - visita inicial (obturación/ calcificación apical, reparación de perforaciones, reabsorción de la raíz, etc.) | 150 |
| D3352 | Apexificación/recalcificación - cambio de medicación a mitad del tratamiento (obturación/calcificación apical, reparación de perforaciones, reabsorción de la raíz, etc.) | 95 |
| D3353 | Apexificación/recalcificación - visita final (incluye terapia endodóntica completa - obturación/calcificación apical, reparación de perforaciones, reabsorción de la raíz, etc.) | 120 |
| | **APICECTOMÍA Y SERVICIOS PERIRRADICULARES** | |
| D3410 | Apicectomía y cirugía perirradicular - anterior | 90 |
| D3421 | Apicectomía y cirugía perirradicular - bicúspide (primera raíz) | 90 |
| D3425 | Apicectomía y cirugía perirradicular - molar (primera raíz) | 90 |
| D3426 | Apicectomía y cirugía perirradicular (cada raíz adicional) | 40 |
| D3430 | Relleno retrógrado - por raíz | 0 |
| D3450 | Amputación radicular - por raíz | 0 |

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| | **OTROS PROCEDIMIENTOS ENDODÓNTICOS** | |
| D3910 | Procedimiento quirúrgico para el aislamiento dental con dique de goma | 0 |
| D3920 | Hemisección (incluyendo cualquier extracción de raíz), pero no incluye la terapia endodóntica | 55 |
| D3950 | Preparación del conducto y adaptación de poste o perno prefabricados | 0 |
| | **SERVICIOS QUIRÚRGICOS** | |
| | **(incluye la atención posoperatoria habitual)** | |
| D4210 | Gingivectomía o gingivoplastia - cuatro o más piezas dentarias contiguas o espacios interdentales por cuadrante | 65 |
| D4211 | Gingivectomía o gingivoplastia - de una a tres piezas dentarias contiguas o espacios interdentales por cuadrante | 30 |
| D4240 | Cirugía periodontal con pulido radicular - cuatro o más piezas dentarias contiguas o espacios interdentales por cuadrante | 55 |
| D4241 | Cirugía periodontal con pulido radicular - una a tres piezas dentarias contiguas o espacios interdentales por cuadrante | 22 |
| D4245 | Colgajo en posición apical | 70 |
| D4249 | Alargamiento coronario clínico - tejidos duros | 75 |
| D4260 | Cirugía ósea (incluye inserción y obturación de colgajo) - cuatro o más piezas dentarias contiguas o espacios interdentales por cuadrante | 100 |
| D4261 | Cirugía ósea (incluye inserción y obturación de colgajo) - una a tres piezas dentarias contiguas o espacios interdentales por cuadrante | 40 |
| D4263 | Injerto de reemplazo óseo - primero en cuadrante | 120 |
| D4264 | Injerto de reemplazo óseo - cada sitio adicional en cuadrante | 92 |
| D4274 | Procedimiento de acuñamiento distal o proximal (cuando no se realiza de manera simultánea con otros procedimientos quirúrgicos en la misma área anatómica) | 50 |
| | **SERVICIOS PERIODONTALES NO QUIRÚRGICOS** | |
| D4341 | Curetaje y pulido radicular - cuatro o más piezas dentarias por cuadrante | 35 |
| D4342 | Curetaje y pulido radicular - una a tres piezas dentarias por cuadrante | 9 |
| D4355 | Desbridamiento bucal completo para facilitar la evaluación y el diagnóstico integral | 35 |
| D4381 | Administración localizada de agentes antimicrobianos por medio de un vehículo de liberación controlada en el tejido crevicular enfermo, por pieza dentaria, por informe | 43 |
| | **OTROS SERVICIOS PERIODONTALES** | |
| D4910 | Mantenimiento periodontal | 40 |
| D4920 | Cambio de apósito no programado (por una persona que no sea el dentista tratante) | 30 |
| | **PRÓTESIS REMOVIBLES COMPLETAS** | |
| | **(incluye la atención de rutina después del trabajo dental)** | |
| D5110 | Prótesis removible completa - maxilar | 294 |
| D5120 | Prótesis removible completa - mandibular | 294 |
| D5130 | Prótesis removible inmediata - maxilar | 307 |
| D5140 | Prótesis removible inmediata - mandibular | 307 |
| | **PRÓTESIS REMOVIBLES PARCIALES** | |
| | **(incluye la atención de rutina después del trabajo dental)** | |
| D5211 | Prótesis removible parcial maxilar - a base de resina (incluye ganchos convencionales, apoyos y piezas dentarias) | 250 |
| D5212 | Prótesis removible parcial mandibular - a base de resina (incluye ganchos convencionales, apoyos y piezas dentarias) | 250 |
| D5213 | Prótesis removible parcial maxilar - estructura de metal colado con base de prótesis removible de resina (incluye ganchos convencionales, apoyos y piezas dentarias) | 345 |
| D5214 | Prótesis removible parcial mandibular - marco de metal colado con base de prótesis removible de resina (incluye ganchos convencionales, apoyos y piezas dentarias) | 345 |
| D5225 | Prótesis removible parcial maxilar - base flexible (incluye ganchos, apoyos y piezas dentarias) | 397 |
| D5226 | Prótesis removible parcial mandibular - base flexible (incluye ganchos, apoyos y piezas dentarias) | 397 |
| D5281 | Prótesis removible parcial unilateral - una sola pieza de metal colado (incluye ganchos y piezas dentarias) | 148 |
| | **AJUSTES DE PRÓTESIS REMOVIBLES** | |
| D5410 | Ajuste de prótesis removible total - maxilar | 13 |
| D5411 | Ajuste de prótesis removible total - mandibular | 18 |
| D5421 | Ajuste de prótesis removible parcial - maxilar | 18 |
| D5422 | Ajuste de prótesis removible parcial - mandibular | 18 |
| | **REPARACIONES DE PRÓTESIS REMOVIBLES TOTALES** | |
| D5510 | Reparación de fractura en base de prótesis removible total | 35 |
| D5520 | Reposición de piezas dentarias fracturadas o faltantes – prótesis removible total (por cada pieza dentaria) | 29 |
| | **REPARACIONES DE PRÓTESIS REMOVIBLES PARCIALES** | |
| D5610 | Reparación de prótesis removible a base de resina | 34 |
| D5620 | Reparación de estructura colada | 35 |
| D5630 | Reparación o reposición de ganchos estropeados | 35 |
| D5640 | Reemplazo de piezas dentarias fracturadas - por pieza dentaria | 32 |
| D5650 | Agregado de piezas dentarias a una prótesis removible parcial existente | 37 |
| D5660 | Agregado de ganchos a una prótesis removible parcial existente | 44 |
| D5670 | Reposición de todas las piezas dentarias y el acrílico de una estructura de metal colado (maxilar) | 225 |
| D5671 | Reposición de todas las piezas dentarias y el acrílico de una estructura de metal colado (mandibular) | 225 |
| | **PROCEDIMIENTOS DE REBASE DE PRÓTESIS REMOVIBLES** | |
| D5710 | Rebase de prótesis removible maxilar total | 97 |
| D5711 | Rebase de prótesis removible mandibular total | 105 |
| D5720 | Rebase de prótesis removible maxilar parcial | 52 |
| D5721 | Rebase de prótesis removible mandibular parcial | 67 |
| | **PROCEDIMIENTOS DE RECUBRIMIENTO DE PRÓTESIS REMOVIBLES** | |
| D5730 | Recubrimiento de prótesis removible maxilar total (en consultorio) | 70 |
| D5731 | Recubrimiento de prótesis removible mandibular total (en consultorio) | 70 |
| D5740 | Recubrimiento de prótesis removible maxilar parcial (en consultorio) | 53 |
| D5741 | Recubrimiento de prótesis removible mandibular parcial (en consultorio) | 56 |
| D5750 | Recubrimiento de prótesis removible maxilar total (en laboratorio) | 75 |
| D5751 | Recubrimiento de prótesis removible mandibular total (en laboratorio) | 75 |
| D5760 | Recubrimiento de prótesis removible maxilar parcial (en laboratorio) | 65 |
| D5761 | Recubrimiento de prótesis removible mandibular parcial (en laboratorio) | 65 |
| D5810 | Prótesis removible total temporal - maxilar | 307 |
| D5811 | Prótesis removible total temporal - mandibular | 307 |
| D5820 | Prótesis removible parcial temporal - maxilar | 125 |
| D5821 | Prótesis removible parcial temporal - mandibular | 125 |
| | **OTROS SERVICIOS PARA PRÓTESIS REMOVIBLES** | |
| D5850 | Acondicionamiento del tejido, maxilar | 30 |
| D5851 | Acondicionamiento del tejido, mandibular | 30 |
| | **PÓNTICOS PARA PRÓTESIS PARCIALES FIJAS** | |
| D6205 | Póntico - compuesto indirecto a base de resina | 201 |
| D6210 | Póntico - metal muy noble colado | 210◆ |
| D6211 | Póntico - metal base predominante colado | 200 |
| D6212 | Póntico - metal noble colado | 210◆ |
| D6214 | Póntico - titanio | 200 |
| D6240 | Póntico - porcelana fundida con metal muy noble | 225◆ |

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| D6241 | Póntico - porcelana fundida con metal base predominante | 210 |
| D6242 | Póntico - porcelana fundida con metal noble | 225 ◆ |
| D6245 | Póntico - porcelana/cerámica | 201 |
| D6250 | Póntico - resina con metal muy noble | 225 ◆ |
| D6251 | Póntico - resina con metal base predominante | 210 |
| D6252 | Póntico - resina con metal noble | 225 ◆ |
| | **RETENEDORES PARA PRÓTESIS PARCIALES FIJAS - INTRA- Y EXTRACORONARIAS (INLAYS Y ONLAYS)** | |
| D6545 | Retenedor - metal colado para prótesis fija adherida con resina | 138 |
| D6548 | Retenedor - porcelana/cerámica para prótesis fija adherida con resina | 207 |
| D6602 | Incrustación intracoronaria (inlay) - metal muy noble colado, dos superficies | 185 ◆ |
| D6603 | Incrustación intracoronaria (inlay) - metal muy noble colado, tres o más superficies | 190 ◆ |
| D6604 | Incrustación intracoronaria (inlay) - metal base predominante colado, dos superficies | 185 |
| D6605 | Incrustación intracoronaria (inlay) - metal base predominante colado, tres o más superficies | 190 |
| D6606 | Incrustación intracoronaria (inlay) - metal noble colado, dos superficies | 185 ◆ |
| D6607 | Incrustación intracoronaria (inlay) - metal noble colado, tres o más superficies | 190 ◆ |
| D6610 | Incrustación extracoronaria (onlay) - metal muy noble colado, dos superficies | 174 ◆ |
| D6611 | Incrustación extracoronaria (onlay) - metal muy noble colado, tres o más superficies | 195 ◆ |
| D6612 | Incrustación extracoronaria (onlay) - metal base predominante colado, dos superficies | 174 |
| D6613 | Incrustación extracoronaria (onlay) - metal base predominante colado, tres o más superficies | 195 |
| D6614 | Incrustación extracoronaria (onlay) - metal noble colado, dos superficies | 174 ◆ |
| D6615 | Incrustación extracoronaria (onlay) - metal noble colado, tres o más superficies | 195 ◆ |
| D6624 | Incrustación intracoronaria (inlay) – titanio | 190 |
| D6634 | Incrustación extracoronaria (onlay) – titanio | 195 |
| | **RETENEDORES PARA PRÓTESIS PARCIALES FIJAS - CORONAS** | |
| D6710 | Corona - compuesto indirecto a base de resina | 237 |
| D6720 | Corona - resina con metal muy noble | 237 ◆ |
| D6721 | Corona - resina con metal base predominante | 210 |
| D6722 | Corona - resina con metal noble | 221 ◆ |
| D6740 | Corona - porcelana/cerámica | 237 |
| D6750 | Corona - porcelana fundida con metal muy noble | 237 ◆ |
| D6751 | Corona - porcelana fundida con metal base predominante | 214 |
| D6752 | Corona - porcelana fundida con metal noble | 223 ◆ |
| D6780 | Corona - 3/4 de metal muy noble colado | 210 ◆ |
| D6781 | Corona - 3/4 de metal base predominante colado | 210 |
| D6782 | Corona - 3/4 de metal noble colado | 210 ◆ |
| D6783 | Corona - 3/4 de porcelana/cerámica | 237 |
| D6790 | Corona - colado completo de metal muy noble | 219 ◆ |
| D6791 | Corona - colado completo de metal base predominante | 210 |
| D6792 | Corona - colado completo de metal noble | 210 ◆ |
| D6794 | Corona - titanio | 210 |
| | **OTROS SERVICIOS PARA PRÓTESIS PARCIALES FIJAS** | |
| D6930 | Recementado de una prótesis parcial fija | 32 |
| D6940 | Reductor de estrés | 130 |
| D6950 | Anclaje de precisión | 222 |
| D6970 | Poste y núcleo, además del retenedor de una prótesis parcial fija, fabricado indirectamente | 70 |
| D6972 | Poste y núcleo prefabricados, además del retenedor de una prótesis parcial fija | 60 |
| D6973 | Reconstrucción del núcleo para retenedor, incluye espigas | 46 |
| D6976 | Cada poste adicional fabricado indirectamente - misma pieza dentaria | 10 |
| D6977 | Cada poste adicional prefabricado - misma pieza dentaria | 10 |
| D6980 | Reparación de prótesis parcial fija, por informe | 25 |
| | **EXTRACCIONES** | |
| | **(incluye anestesia local, sutura, si fuera necesaria, y atención posquirúrgica de rutina)** | |
| D7111 | Extracción, remanentes de coronas - pieza dentaria temporal | 6 |
| D7140 | Extracción de pieza dentaria erupcionada o raíz expuesta (extracción con elevadores o fórceps) | 15 |
| | **EXTRACCIONES QUIRÚRGICAS** | |
| | **(incluye anestesia local, sutura, si fuera necesaria, y atención posquirúrgica de rutina)** | |
| D7210 | Extracción quirúrgica de una pieza dentaria erupcionada con elevación de colgajo mucoperióstico y osteotomía y/o sección de la pieza dentaria | 35 |
| D7220 | Extracción de una pieza dentaria impactada - en tejido blando | 40 |
| D7230 | Extracción de una pieza dentaria impactada - en tejido óseo parcial | 45 |
| D7240 | Extracción de una pieza dentaria impactada - en tejido óseo total | 50 |
| D7241 | Extracción de una pieza dentaria impactada - en tejido óseo total, con complicaciones quirúrgicas poco comunes | 55 |
| D7250 | Extracción quirúrgica de raíces dentales residuales (procedimiento de corte) | 30 |
| | **OTROS PROCEDIMIENTOS QUIRÚRGICOS** | |
| D7280 | Acceso quirúrgico a una pieza dentaria retenida | 32 |
| D7283 | Colocación de un dispositivo para facilitar la erupción de una pieza dentaria impactada | 8 |
| D7285 | Biopsia de tejidos bucales - duros (hueso, pieza dentaria) | 78 |
| D7286 | Biopsia de tejidos bucales - blandos | 90 |
| D7288 | Biopsia por cepillado - toma de muestra transepitelial | 45 |
| | **ALVEOLOPLASTIA** | |
| | **(preparación quirúrgica de los alvéolos para prótesis)** | |
| D7310 | Alveoloplastia con extracciones - cuatro o más piezas o espacios dentales, por cuadrante | 25 |
| D7311 | Alveoloplastia con extracciones - una a tres piezas o espacios dentales, por cuadrante | 15 |
| D7320 | Alveoloplastia sin extracciones - cuatro o más piezas o espacios dentales, por cuadrante | 35 |
| D7321 | Alveoloplastia sin extracciones - una a tres piezas o espacios dentales, por cuadrante | 14 |
| | **ESCISIÓN QUIRÚRGICA DE LESIONES INTRAÓSEAS** | |
| D7450 | Extirpación de quiste o tumor odontógeno benigno - lesión con diámetro de hasta 1.25 cm | 55 |
| D7451 | Extirpación de quiste o tumor odontógeno benigno - lesión con diámetro mayor de 1.25 cm | 250 |
| | **ESCISIÓN DEL TEJIDO ÓSEO** | |
| D7471 | Extirpación de exostosis lateral (maxilar o mandibular) | 250 |
| D7472 | Extirpación del torus palatinus | 250 |
| D7473 | Extirpación del torus mandibularis | 250 |
| D7485 | Reducción quirúrgica de tuberosidad ósea | 385 |
| | **INCISIÓN QUIRÚRGICA** | |
| D7510 | Incisión y drenaje de absceso - tejido blando intraoral | 50 |
| D7511 | Incisión y drenaje de absceso - tejido blando intraoral, con complicaciones (incluye drenaje de múltiples espacios fasciales) | 95 |
| D7520 | Incisión y drenaje de absceso - tejido blando extraoral | 75 |

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| D7521 | Incisión y drenaje de absceso - tejido blando extraoral, con complicaciones (incluye drenaje de múltiples espacios fasciales) | 115 |
| | **REPARACIÓN DE HERIDAS TRAUMÁTICAS** | |
| D7910 | Sutura de heridas pequeñas recientes de hasta 5 cm | 100 |
| | **OTROS PROCEDIMIENTOS DE REPARACIÓN** | |
| D7960 | Frenulectomía (frenectomía o frenotomía) - procedimiento independiente | 23 |
| D7963 | Frenuloplastia | 12 |
| D7970 | Escisión de tejido hiperplásico - por arco | 66 |
| D7971 | Escisión de tejido gingival pericoronario | 36 |
| | **TRATAMIENTO ORTODÓNTICO LIMITADO** | |
| D8010 | Tratamiento ortodóntico limitado de la dentición primaria | 1,500 |
| D8020 | Tratamiento ortodóntico limitado de la dentición de transición | 1,500 |
| D8030 | Tratamiento ortodóntico limitado de la dentición del adolescente | 1,500 |
| D8040 | Tratamiento ortodóntico limitado de la dentición del adulto | 1,500 |
| | **TRATAMIENTO ORTODÓNTICO DE INTERCEPCIÓN** | |
| D8050 | Tratamiento ortodóntico de intercepción de la dentición primaria | 1,500 |
| D8060 | Tratamiento ortodóntico de intercepción de la dentición de transición | 1,500 |
| | **TRATAMIENTO ORTODÓNTICO INTEGRAL** | |
| D8070 | Tratamiento ortodóntico integral de la dentición de transición | 1,500 |
| D8080 | Tratamiento ortodóntico integral de la dentición del adolescente | 1,500 |
| D8090 | Tratamiento ortodóntico integral de la dentición del adulto | 2,000 |
| | **TRATAMIENTO MENOR PARA EL CONTROL DE MALOS HÁBITOS** | |
| D8210 | Terapia con aparatos removibles | 750 |
| D8220 | Terapia con aparatos fijos | 750 |
| | | |
| D8660 | Visita de tratamiento preortodóntico | 40 |
| D8670 | Visita de tratamiento ortodóntico periódico (como parte del contrato) | 0 |
| D8680 | Retención ortodóntica (extracción de aparatos, construcción y colocación de retenedor(es)) | 240 |
| † | Tarifa por expedientes ortodónticos | 265 |
| | **TRATAMIENTO NO CLASIFICADO** | |
| D9110 | Tratamiento paliativo (de emergencia) para el dolor dental - procedimiento menor | 8 |
| D9120 | División de prótesis parcial fija | 70 |
| | **ANESTESIA** | |
| D9210 | Anestesia local sola, sin procedimientos quirúrgicos ni operativos | 0 |
| D9211 | Anestesia por bloqueo regional | 0 |
| D9212 | Anestesia por bloqueo del trigémino | 0 |
| D9215 | Anestesia local | 0 |
| D9220 | Sedación profunda/anestesia general - los primeros 30 minutos | 160 |
| D9221 | Sedación profunda/anestesia general - por cada fracción adicional de 15 minutos | 68 |
| D9241 | Sedación consciente intravenosa/analgésica - los primeros 30 minutos | 170 |
| D9242 | Sedación consciente intravenosa/analgésica - por cada fracción adicional de 15 minutos | 42 |

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| | **CONSULTA PROFESIONAL** | |
| D9310 | Consulta - servicio de diagnóstico proporcionado por un dentista o un médico distinto del dentista o del médico que lo solicita | 0 |
| | **VISITAS A PROFESIONALES** | |
| D9430 | Visita al consultorio para observación (en horarios hábiles normales) - no se realiza ningún otro servicio | 0 |
| D9440 | Visita al consultorio, fuera de los horarios hábiles normales | 40 |
| D9450 | Presentación de caso, planeación amplia y detallada del tratamiento | 0 |
| | **SERVICIOS VARIOS** | |
| D9940 | Protector oclusal, por informe | 200 |
| D9942 | Reparación y/o revestimiento de protector oclusal | 65 |
| D9951 | Ajuste oclusal - limitado | 15 |
| D9952 | Ajuste oclusal - total | 60 |
| ★ | Incumplimiento de la cita concertada, por 30 minutos (sin aviso previo de 24 horas) | 20 |
| | **BLANQUEADO** | |
| D9972 | Blanqueado externo - por arco | 185 |

**NOTAS A PIE DE PÁGINA**

† Cuando informe sobre estos procedimientos, utilice el código D8999 "Procedimiento de ortodoncia no especificado, por informe". Los expedientes incluyen todos los procedimientos de diagnóstico, tales como radiografías cefalométricas, radiografías de boca completa, modelos y planes de tratamiento.

★ Cuando informe sobre estos procedimientos, utilice el código D9999 "Procedimiento complementario no especificado, por informe".

◆ Los cargos por el uso de metales preciosos (muy nobles) o semipreciosos (nobles) no están incluidos en los copagos de las coronas, los puentes, los pónticos, y las incrustaciones intracoronarias (inlays) y extracoronarias (onlays). La decisión de usar estos materiales debe ser acordada entre el proveedor y el paciente, de acuerdo con el consejo profesional del proveedor. Se espera que los proveedores no cobren más de $125 adicionales por estos materiales.

# *LISTA DE EXCLUSIONES Y LIMITACIONES*

**EXCLUSIONES:**

**A menos que así lo especifique este Certificado, no se dará cobertura a los servicios, suministros o cargos:**

1. Que no aparezcan indicados en la Lista de Beneficios como Servicio Cubierto.
2. Provistos a un Afiliado fuera del consultorio al que pertenece el Afiliado y que no hayan sido autorizados previamente por la Compañía (incluido los servicios de atención especializada).
3. Que de acuerdo con la opinión del dentista tratante, o de la Compañía, no sean clínicamente necesarios, o que no tengan un pronóstico razonable o favorable.
4. Que sean necesarios debido a la falta de cooperación con el dentista tratante o incumplimiento del Plan de Tratamiento recomendado profesionalmente.
5. Que hayan tenido lugar o iniciado antes de la elegibilidad del Afiliado para la compañía o después de la Fecha de Terminación de la cobertura de la Compañía.
6. Por consultas a un Dentista de Atención Especializada cuyos servicios no aparezcan indicados en la Lista de Beneficios como Servicio Cubierto.
7. Que no cumplan con los estándares aceptados para el tratamiento dental, debido a su naturaleza Experimental o de Investigación, o porque hayan sido considerados por la compañía como mejoras al tratamiento dental estándar.
8. Por hospitalizaciones y costos relacionados con la prestación de servicios en un hospital.
9. Que sean determinados por la Compañía como responsabilidad de la Compensación del Trabajador o del plan de atención de la salud del empleador o su responsabilidad legal, o que sean pagaderos por cualquier programa estatal o del Gobierno Federal, o que sean considerados como tratamiento de una lesión automovilística en la que el Afiliado esté sujeto al pago por parte de una póliza de seguro automotor, o servicios cuyos beneficios estén cubiertos por cualquier otro tipo de seguro.
10. Por medicamentos recetados y de venta libre, productos de atención en el hogar, vitaminas o suplementos dietéticos.
11. Que sean de naturaleza Cosmética según lo determine la Compañía, incluyendo, entre otros, blanqueamientos, carillas labiales, personalización o caracterización de coronas, puentes y/o prótesis removibles.
12. Por servicios de diagnóstico y tratamiento de problemas de articulación mandibular con el uso de cualquier método. Estos problemas de articulación mandibular incluyen, entre otros, afecciones como alteración de la articulación temporomandibular (TMJ, por sus siglas en inglés) y disfunción craneomandibular u otros trastornos de la articulación que conecta el hueso de la mandíbula y el complejo de músculos, nervios y otros tejidos relacionados con la articulación.
13. Por servicios y/o aparatos que alteren la dimensión vertical o que modifiquen, restablezcan o mantengan la oclusión, incluyendo, entre otros, la rehabilitación oral completa, ferulización, aparatos o cualquier otro método.
14. Que reparen la pérdida de la estructura dental por desgaste, erosión o fricción.
15. Por reemplazo de dispositivos protésicos o aparatos ortodónticos debido a su pérdida, extravío, robo o daño; y por prótesis removibles o dispositivos protésicos duplicados o por cualquier otro aparato duplicado.
16. Que no están incluidos como beneficios ortodónticos, tales como el retratamiento de casos ortodónticos, cambios en el tratamiento ortodóntico debido a la falta de cooperación del paciente, reparaciones de aparatos ortodónticos, reposición de aparatos perdidos o robados, aparatos especiales (incluyendo, entre otros, aparatos extraorales, aparatos ortopédicos, placas de mordida, aparatos funcionales o expansor palatino), terapia miofuncional, los casos que necesiten de cirugía ortognática, extracciones para fines ortodónticos, y tratamientos que superan los veinticuatro (24) meses.
17. Por implantes, inserciones o extracciones quirúrgicas, así como por cualquier aparato o prótesis adherido a los implantes.
18. Que sean requeridos debido a, o en conexión con, actos de guerra, declarados o no declarados.
19. Por procedimientos electivos, incluyendo, entre otros, extracciones profilácticas de terceros molares.

**LIMITACIONES**

**Los siguientes servicios estarán sujetos a limitaciones, como se establece a continuación:**

1. La remisión a un Dentista de Atención Especializada queda limitada a dentistas especializados en ortodoncia, cirugía oral, periodoncia, endodoncia y pediatría.
2. La cobertura para la remisión a un Dentista de Atención Especializada en pediatría termina cuando el Afiliado cumple los 7 años. Sin embargo, se podrían considerar ciertas excepciones, de forma individual, para los niños que tienen discapacidad física o mental, o afecciones médicas, siempre que sean confirmadas por un médico, y con la aprobación previa de la Compañía.
3. Los miembros deben permanecer en el Plan durante el periodo de tiempo que reciban su tratamiento ortodóntico. Cualquier terminación anticipada puede resultar en cargos adicionales por todos los trabajos incompletos. Esta limitación aplica únicamente para la terminación de la cobertura del suscritor, y no para la terminación de la cobertura grupal.
4. Los sellantes (1) uno por pieza dentaria por un periodo de tres (3) años hasta los diez (10) años en los primeros molares permanentes y hasta los quince (15) en los segundos molares permanentes.
5. En el caso de una Emergencia Dental con dolor o una afección que requiera el tratamiento inmediato y que se produzca a más de cincuenta (50) millas de la casa del Afiliado, el Plan cubre el diagnóstico necesario y los procedimientos dentales terapéuticos administrados por un dentista hasta un máximo de $100 por cada visita de emergencia.
6. El mantenimiento periodontal después de una terapia periodontal activa – dos (2) por periodo de doce (12) meses junto con profilaxis de rutina.
7. Curetaje y alisado radicular - uno (1) por período de veinticuatro (24) meses por cada área de la boca.
8. Procedimientos periodontales quirúrgicos - uno (1) por periodo de treinta y seis (36) meses por cada área de la boca.
9. Retratamiento de endodoncia – uno (1) por pieza dentaria, una vez en la vida.
10. Radiografías panorámicas o bucales completas - una (1) cada tres (3) años.
11. Una (1) serie de radiografías de aleta de mordida cada seis (6) meses consecutivos.
12. Profilaxis - una (1) cada seis (6) meses consecutivos, a menos que se indique lo contrario en la Lista de Beneficios.
13. Tratamiento de flúor - uno (1) cada seis (6) meses consecutivos hasta los dieciocho (18) años.
14. Alargamiento coronario – uno (1) por pieza dentaria, una vez en la vida.
15. Rebase o revestimiento de prótesis removible- integral si tiene lugar en un plazo de seis (6) meses desde el procedimiento de inserción y con el mismo dentista. Esta limitación no aplica para las prótesis removibles inmediatas.
16. El rebase o revestimiento subsiguientes de la prótesis removible- se limita a uno (1) cada treinta y seis (36) meses después del procedimiento.
17. La administración de sedación intravenosa o anestesia general está limitada a la cobertura de los procedimientos quirúrgicos orales relacionados con uno o más dientes impactados (tejido blando, impacto óseo parcial o completo).

# DAVIS VISION *Beneficios que Usted Puede Ver*

## 1. PROGRAMA DE DESCUENTOS

Davis Vision se complace en ofrecerle un tradicional Programa de Descuentos de la vista a bajo costo, con el que obtendrá importantes descuentos en exámenes de la vista, cristales, marcos y otros artículos de óptica opcionales. Visite a un proveedor de la vista participante y presente su tarjeta de descuentos junto con el Código de Control. Con casi 26,000 proveedores de la vista participantes, puede encontrar un proveedor cerca de su casa llamando a nuestra línea gratuita del sistema de Respuesta Interactiva de Voz (IVR) o visitando el sitio en Internet de Davis Vision, en **www.davisvision.com**. Para más detalles, vea la sección Información de Acceso a Beneficios y Proveedores, al reverso.

El Programa de Descuentos le permite obtener los siguientes descuentos sobre los precios usuales y acostumbrados:

| | |
|---|---|
| **Plan de la Vista:** | Programa de Descuentos Vantage Affinity |
| **Código de Control/Número de Control del Cliente:** | 7602 |
| **Copago:** | No corresponde; el plan de descuento es el 100% de lo que el afiliado pagó en el momento del servicio |
| **Lens 123®:** | Descuentos por reemplazo de lentes de contacto de 1-800-LENS123 |
| **Corrección de la Vista con Láser:** | Descuentos de proveedores participantes para corrección de la vista con láser |

| PROGRAMA DE DESCUENTOS DE DAVIS VISION | COSTO PARA EL AFILIADO |
|---|---|
| **Examen de la vista** | |
| Examen Completo | 15% de descuento sobre el precio Usual y Acostumbrado |
| Examen de Lentes de Contacto | 15% de descuento sobre el precio Usual y Acostumbrado |
| **Marcos** | |
| Marcos—hasta $70.00 al público | $40.00 |
| Marcos–más de $70.00 al público | $40.00 más el 10% de descuento cuando el monto supere $70.00 |
| **Cristales para Anteojos** | |
| Cristales Monofocales | $35.00 |
| Cristales Bifocales | $55.00 |
| Cristales Trifocales | $65.00 |
| Cristales Lenticulares | $110.00 |
| **Opciones (Agregar a los Precios de los Cristales para Anteojos)** | |
| Cristales Progresivos Estándar | $75.00 |
| Cristales Progresivos Premium | $125.00 |
| Polarizados | $75.00 |
| Cristales de Alto Índice | $55.00 |
| Cristales de Vidrio | $18.00 |
| Cristales de Policarbonato | $30.00 |
| Bifocales Invisibles | $20.00 |
| Cristales de Vista Intermedia | $30.00 |
| Revestimiento Protector | $15.00 |
| Tratamiento Antirreflejo | $45.00 |
| Revestimiento Ultravioleta | $15.00 |
| Color Uniforme | $10.00 |
| Color Degradado | $12.00 |
| Cristales PGX | $35.00 |
| Cristales Fotosensibles de Plástico | $65.00 |
| **Lentes de Contacto** | |
| 20% de descuento convencional | Sobre el precio Usual y Acostumbrado |
| Descartables/Reemplazo Planificado | 10% de descuento sobre el precio Usual y Acostumbrado |
| Lens 123® | Membresía gratis con hasta el 60% de descuento Precios al Público |

*Lista de Descuentos, continuación...*

DAVIS VISION
THE EYECARE ADVANTAGE

Esta tarjeta le permite al titular y a su familia obtener precios con descuentos especiales

**Nombre** _____

**Grupo** United Concordia

**Código Control** 7602

**Firma** _____

*Beneficios que usted puede ver.*

*Lista de Descuentos, continuación...*

**Otros Productos**

| | |
|---|---|
| Anteojos para Sol sin Receta | 20% de descuento sobre el precio Usual y Acostumbrado |
| Otros Productos/Soluciones Complementarios | 10% de descuento sobre el precio Usual y Acostumbrado |
| Corrección Láser de la Vista | Hasta un 25% de descuento sobre el precio Usual y Acostumbrado |

Nota: Todos los diseños de lentes, materiales, graduación y marcos especiales pueden requerir un pago adicional.

## 2. LENS 123®

Lens 123® es un programa de pedido por correo postal que le permite disfrutar de los precios más bajos garantizados en el reemplazo de lentes de contacto—ahorre hasta un 60% sobre los precios al público. Los Afiliados pueden llamar convenientemente al 1-800-LENS123 con una receta actual para este servicio de valor agregado. El programa de reemplazo de lentes de contacto Lens 123® está respaldado por los principales fabricantes de la industria.

## 3. CORRECCIÓN DE LA VISTA CON LÁSER

El programa Corrección de la Vista con Láser de Davis Vision brinda sustanciales descuentos en los procedimientos de corrección de la vista con láser. Los Afiliados tienen derecho a ahorros de hasta un 25% sobre los precios usuales y acostumbrados, o a un descuento del 5% en la oferta especial publicitada, a través de una red de médicos preeminentes afiliados a los centros Eye Centers of Excellence. (Algunos centros brindan una tarifa fija equivalente a estos niveles de descuentos). Consulte a continuación la información para encontrar un proveedor para corrección de la vista con láser en su área.

## CÓMO FUNCIONA EL PROGRAMA DE DESCUENTOS CON SU PLAN

Para obtener descuentos en artículos de óptica, usted puede elegir de una lista de proveedores privados contratados o comercios minoristas contratados de Davis Vision. Si usted ya cuenta con el beneficio del examen de la vista como parte de su plan de salud, puede usar un proveedor de la red dentro de la red de su plan de salud para el examen. Luego use un proveedor contratado de Davis Vision para sus compras de artículos de óptica (anteojos, etc.) y maximice sus ahorros (antes de su cita, debe verificar si el proveedor de Davis Vision acepta recetas externas).

## INFORMACIÓN DE ACCESO A BENEFICIOS Y PROVEEDORES

Si está buscando un proveedor de la vista participante o desea más información acerca del plan de descuentos, Davis Vision ofrece una cantidad de convenientes maneras para que usted obtenga la información que necesita, cuando la necesita.

**SERVICIOS AUTOMÁTICOS** (Disponibles las 24 horas, los 7 días de la semana)

**En Internet**—Para acceder al Menú de Descuentos de Davis Vision para Afiliados de United Concordia, visite **www.davisvision.com** y seleccione "Find a Provider" (Encuentre un Proveedor). En el segundo cuadro, ingrese el Código de Control 7602 y haga clic en "Enviar". Desde el Menú de Afiliados puede encontrar un proveedor, revisar sus beneficios, obtener un número de confirmación para cirugía con láser, completar una encuesta de satisfacción, visitar Lens 123® para comprar lentes de contacto de reemplazo ¡y mucho más!

**Por teléfono**—Para acceder al sistema de Respuesta Interactiva de Voz (IVR), llame al Servicio de Atención al Cliente de Davis Vision al **1-877-923-2847** e ingrese el Número de Control del Cliente 7602 cuando se lo soliciten. Seleccione la opción de menú apropiada utilizando el teclado de su teléfono.

**SERVICIO AL CLIENTE**

Para hablar con un representante de este sector, llame al Servicio al Cliente de Davis Vision al 1-877-923-2847. Ingrese el Número de Control del Cliente 7602 cuando se lo soliciten. En el menú principal, presione "0". Nuestros representantes se encuentran disponibles para ayudarlo de lunes a viernes, desde las 8 a.m. hasta las 11 p.m. hora del Este, los sábados, de 9 a.m. a 4 p.m. hora del Este y los domingos, de 12 p.m. to 4 p.m., hora del Este.

DAVIS VISION™
THE EYECARE ADVANTAGE

**SERVICIO AL CLIENTE**
**1-877-923-2847**

UNITED CONCORDIA
Insuring America's Dental Health