United Concordia dental℠

February 4, 2025

EFFINGHAM COUNTY BOARD OF EDUCATION
405 N ASH STREET
SPRINGFIELD, GA 31329

Welcome to United Concordia Dental. We're pleased to have you as a new customer, and we look forward to a long relationship together.

Enclosed is an Administrative Procedure Kit which includes general information about your services and a copy of your Group Insurance Policy for Dental Benefits. The Group Insurance Policy document includes your benefits, rates, Certificate(s) of Coverage/Insurance and the general terms of our relationship.

Employees enrolled in the plan can access their Certificates of Coverage/Insurance by logging into their ***MyDental****Benefits* accounts on UnitedConcordia.com.

If you still have questions about your new dental benefits, we're here to help. Just contact your Sales/Service Representative, call Customer Service at 800-332-0366 or visit UnitedConcordia.com.

Again, thank you for choosing United Concordia as your dental carrier. We look forward to serving you and your members.

Sincerely,

Your United Concordia Account Installation Team

Helpful plan information

United Concordia dental℠

Employer Points of Contact

Contact	Phone/Fax	Responsibilities
Enrollment and Billing Representative	**Phone:** 1-888-320-3316 **Fax:** 1-800-329-9093	• Enrollment and premium invoice questions • Group Administration Portal questions • eBill • Electronic enrollment discrepancies • Paper enrollment add/change
Client Manager	Contact your Client Manager or the Small Business Unit at 1-800-972-4191	• Benefit changes • Renewal rates • Open enrollment

Cancellation of Group Coverage requires written notification be received sixty (60) days prior to your group's cancellation date. Written notification should include your group number, effective date of cancellation, reason for cancellation and signature of an authorized representative of your group.

Failure to send proper and timely notification will result in additional billed premium.

Mail to:

United Concordia Companies, Inc.
Attn: Enrollment & Billing
1800 Center Street Suite 2B 220
Camp Hill, PA 17011

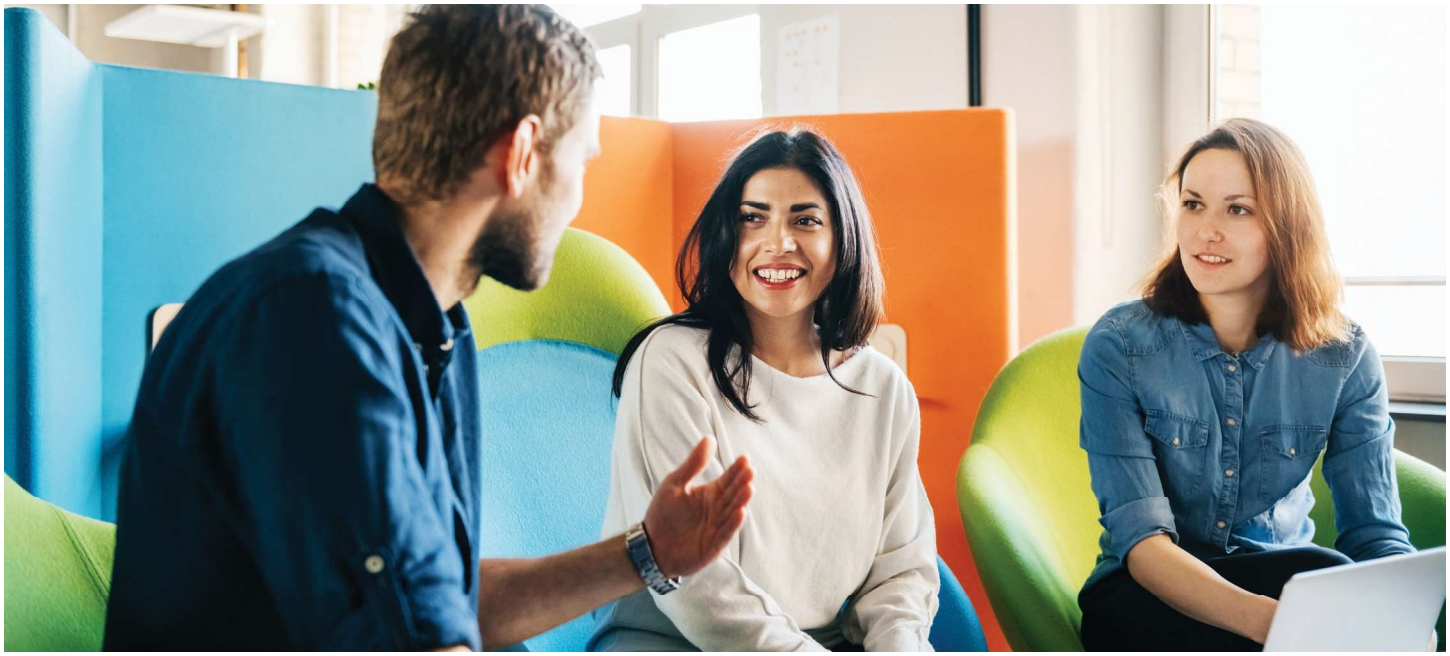
Employer Self-Service

Group Administration Portal For assistance registering 1-888-320-3316	**unitedconcordia.com** • Employer Resource Center Box • 24/7 access	• Connect to eBill • View, add, change or delete enrollment • View and download roster • Pay bills and set up recurring payments • Request ID cards • View and print ID cards
Billing		• Invoice guide • Enrollment and Billing guide
Premium Payments		• Enrollment and Billing guide ***Paying by check?*** *Send your payments to the address listed on your remittance slip.*
Forms		• Print enrollment, claims, HIPAA authorization, dependent certification

Member Self-Service

Member Dental Customer Service	**FFS:** 1-800-332-0366 **DHMO:** 1-866-357-3304 **Email:** Select 'Contact Us' at top of website **unitedconcordia.com**	• Enrollment, benefit and claim inquiries • Request ID cards
Find a Dentist	**unitedconcordia.com** • Login/Create an Account • 24/7 access	• Select your network
My Dental Benefits		• Register • Print virtual ID card • Claim status • View explanation of benefits • Nominate your dentist to be in network
Claims	**FFS Mail to:** United Concordia Claims PO Box 69421 Harrisburg, PA 17106-9421	**DHMO Mail to:** United Concordia Claims PO Box 69422 Harrisburg, PA 17106-9421

United Concordia dental℠



Streamline account management online.

Register for Group Administration

Quickly handle enrollment and billing tasks using our **Group Administration Portal** on UnitedConcordia.com. With a single login, you can access the tools you need to manage member accounts and information.

Highlights:

- **Order member collateral** — Request member welcome/ID card letters.
- **Member ID card access** — View, save, and print member ID cards.
- **Speedy bill pay** — eBill accepts payments, plus lets your broker manage and print invoices.
- **Mobile-friendly platform** — Do business from your laptop, tablet, or smartphone.

Learn how to register for Group Administration.

Two new ways to pay

Guest Pay — Make a one-time premium payment with no registration needed. Secure and easy to use, **Guest Pay** accepts ACH, credit cards, and debit cards.

Make a payment using Guest Pay.

Intelligent IVR — This voice self-service technology lets you make full or partial payments by credit card, debit card, or bank account. You can even connect with a live rep at the end of your call during office hours.

Call 1-888-320-3316 to pay using our IVR system.

United Concordia dental℠



Enrollment and Billing Guide

Managing insurance should be simple and hassle-free.

Section 1 — Enrollment

Options for updating enrollment

Electronic enrollment — Groups can send secure, electronic enrollment transmissions. Contact your account manager for more information.

Web enrollment — Use the enrollment application within the Group Administration Portal to:

- View and print member ID cards.
- View and update member enrollments, changes, and cancellations.
- Request welcome letters and member ID cards.
- Run enrollment rosters.

For more information on registering for the Group Administration Portal, visit the **Employers** section of **UnitedConcordia.com**.

Enrollment forms — Available in the **Employers** and **Brokers** sections on **UnitedConcordia.com**. When submitting a form to United Concordia Dental, please:

- Provide the 9-digit identification number (for example: social security number).
- Provide the 9-digit group number.
- Review for completeness and legibility.

To submit changes, email forms to UCCIenroll@ucci.com, fax forms to 1-800-329-9093, or mail them to:

United Concordia Companies, Inc.
1800 Center Street, Suite 2B 220
Camp Hill, PA 17011

Please note: Incomplete or illegible forms may delay processing.

What if there's no enrollment effective date on the enrollment form?

If we receive the form between the 1st and the 15th of the month, the 1st of the current month will be entered into our system as the effective date.

If we receive the form between the 16th and the last day of the month, the 1st of the following month will be entered as the effective date.

Retroactive enrollment policy

We have a three-month policy for retroactive enrollment additions, cancellations, and changes. To ensure prompt billing adjustments, please submit enrollment changes with effective dates within this period, which includes the current month (in which the request was received), plus the two previous months.



Retroactive enrollment activity outside the three-month window is monitored by United Concordia. It may result in follow-up communication with your group and/or denial of enrollment request(s), if claims were paid with a date of service after a requested cancellation date.

Note: Due to COBRA regulations and requirements, United Concordia will process retroactive COBRA enrollment changes with effective dates within the six-month period prior to the receipt date of the request.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

USERRA provides two types of protection relative to health care coverage for members who serve temporarily in the uniformed services:

- **Continuation of coverage during deployment** — Members have the right to elect continuation of coverage for up to 24 months during deployment, upon payment of premiums as required by the mandate.
- **Reinstatement of coverage after deployment** — Members have the right to request reinstatement of coverage upon reemployment with no preexisting condition exclusion or waiting period, unless the exclusion or waiting period would have applied if the member had not been deployed.

If a member's coverage was previously cancelled and they elect to reinstate coverage during deployment, complete a member enrollment form and the USERRA enrollment form. Fax both forms to 1-800-329-9093. Or mail them to:

United Concordia Companies, Inc.
1800 Center Street, Suite 2B 220
Camp Hill, PA 17011

Find the USERRA enrollment form in the **Employers** and **Brokers** sections on **UnitedConcordia.com**.

Section 2 — Enrollment and Billing Reconciliation

Enrollment and billing representatives reconcile enrollment and billing activity each month. For accurate and timely reconciliations of your group information, let us know about enrollment updates before the next billing cycle.

For an explanation of the invoice, see the Invoice Guide in the **Admin Resources** tab in the **Employers** section on **UnitedConcordia.com**.

Section 3 — eBill

Manage your account using eBill, our convenient, online tool.

eBill allows you to:

- View account billing information.
- Pay your premium online.
- View invoice and online payment history.
- Download your invoice summary and detailed roster.
- Participate with our medical or vision plans and use eBill to make one payment.
- Choose paperless invoices and save paper, energy, and trees.

For more information on registering for the Group Administration Portal, visit the **Employers** section of **UnitedConcordia.com**.

Section 4 — Payment

Premium payments can be made using eBill, check, electronic transfer of funds, pay by phone, or pay as guest.

Sending payments via **eBill**:

- If paying an amount other than what was billed, please include the reason for adjusted payment in the comment box.
- Refer to Section 3 above.

Sending premium payments via **check**:

- Include the invoice remittance slip along with your check. Record your recipient number on the check to ensure timely and accurate processing of your payment.
- Send your payment to the address listed on the remittance slip.

Sending premium payments via **electronic transfer**:

- Include the recipient number and invoice month of premium for proper cash posting.
- Contact Enrollment and Billing for your specific bank information to remit funds electronically.

Sending premium payments via **phone**:

- Contact Enrollment and Billing at 1-888-320-3316 to process your payment by check or credit card.

(Please note, credit card payments are limited to $2,500.)

Section 5 — Cancellation Due to Deliquency

Make payments by the due date specified on the invoice to prevent disruption of service. (Refer to the General Policy/Contract Rules, Section A in your Group Insurance Policy/Group Contract regarding Payment of Premiums.)

Failure to pay an outstanding balance promptly could result in the cancellation of your coverage and you will be responsible for delinquent payment(s) according to the terms outlined in your Group Insurance Policy/Group Contract. (Refer to the General Policy/Contract Rules, Section B-3 regarding the terms outlined for delinquency.)

If you elected to structure your group into two or more subgroups for purposes of independently receiving and paying invoices, United Concordia will treat those subgroups as if they were separate groups to which a separate Group Insurance Policy/Group Contract has been issued for purposes of addressing delinquency in making monthly premium payments. Specifically, United Concordia will issue default notices that will advise the subgroup of a grace period within which overdue payment must be made, as specified in the General Policy/Contract Rules, Section B-3.

Non-payment of the premium due within the specified grace period will result in the cancellation of the members' coverage under the Group Insurance Policy/Group Contract. You may be asked to confirm and verify this cancellation. In the event that delinquency results in cancellation, the subgroup will be notified in writing that coverage of its members will be cancelled as of a specified date.

COBRA Benefits

All states except California:

COBRA is an acronym for the Consolidated Omnibus Budget and Reconciliation Act. The COBRA law was passed to provide current or former employees, their spouses, and dependents with a temporary extension of group health insurance when coverage is lost due to certain events.

The administration of COBRA is the responsibility of the employer. United Concordia Companies, Inc., does not administer COBRA benefits for its plans nor do we directly invoice the COBRA-insured members. We can, however, assist in the administration of this benefit by separately identifying COBRA-insured members on the group invoice as a separate, unique subgroup.

By separating the active members from the COBRA-insured members, the group administrator can readily determine the premium amount to be collected from COBRA-insured members. The group administrator also is allowed to add a two percent (2%) increase to the initial premium to cover the administrative costs for the COBRA insurance.

If you have any questions regarding COBRA administration or if the law applies to your company, we encourage you to seek legal counsel.

California policy:

On January 1, 1998, a new California State Law became effective for employees not covered under federal COBRA. Cal-COBRA (SB719) gives employees of businesses with two to 19 eligible employees the ability to continue any employer-sponsored health care coverage upon occurrence of a qualifying event.

A qualifying event is any of the following events, which would result in loss of health coverage under the group benefit plan:

1. The death of the covered employee or subscriber.
2. The termination or reduction in hours of the employee's employment, except termination for gross misconduct.
3. The divorce or legal separation of the covered employee from the covered employee's spouse.
4. The loss of dependent status by a dependent enrolled in the group benefit plan.
5. With respect to dependents only, the employee's eligibility for coverage under Medicare.

Employees and their dependent spouses and children who are enrolled in their employer's employee benefit plans at the time of a qualifying event are known as "qualified beneficiaries" and are eligible for Cal-COBRA, unless the individual:

- Becomes covered under another group benefit plan, which does not impose any preexisting condition limitations affecting the individual;
- Becomes eligible for federal COBRA;
- Becomes entitled to Medicare;
- Becomes eligible for coverage under the Public Health Service Act;
- Fails to notify the health plan of a qualifying event in the time specified by the law (within 60 days); or
- Fails to pay their premium in a timely manner.

The cost of Cal-COBRA coverage is 110% of the qualified beneficiary's group rate. If a qualified beneficiary is determined to be disabled under Title II or XVI of the United States Social Security Act, the cost changes to 150% of the group rate after the first 18 months of Cal-COBRA coverage.

The qualified beneficiary must notify the Plan (United Concordia) within 60 days of the qualifying events numbered 1, 3, 4 and 5 above. The employer must notify the Plan within 30 days of the event for qualified beneficiaries who qualify due to termination or reduction in hours of employment. If the qualified beneficiary fails to notify the Plan of a qualifying event in time, we are under no obligation to offer the qualified beneficiary Cal-COBRA coverage.

As an employer, your responsibilities under Cal-COBRA are to inform United Concordia of qualifying events and explain to your eligible employees their Cal-COBRA rights.

You must notify qualified beneficiaries of changes or termination of their group benefit plan 30 days prior to making such changes.

If an employee is covered under Cal-COBRA, and his/her former employer becomes eligible for federal COBRA, the qualified beneficiary stays with Cal-COBRA until this coverage is exhausted. However, if any employer's COBRA status changes annually, the following will apply:

1. If the employer's status is Cal-COBRA one year, and changes to federal COBRA the next year, so will the qualified beneficiary's.
2. If the employer's status is federal COBRA and changes to Cal-COBRA, the qualified beneficiary remains under federal COBRA.

Cal-COBRA coverage will terminate on the earliest of the following:

1. 36 months from the date continuation coverage began if continuation was extended because of a termination or reduction in hours of employment;
2. 29 months from the date continuation began if coverage was extended due to qualified beneficiary being incapacitated for Social Security purposes either at the time of the qualifying event or within the first 60 days of continuation coverage;
3. 36 months from the date continuation coverage began if coverage ended for a dependent due to other qualifying events;
4. The end of the period for which the last premium was paid if the qualified beneficiary stops paying premium or does not pay timely or in the correct amount;
5. The date the qualified beneficiary becomes entitled to Medicare or federal COBRA;
6. The date the qualified beneficiary becomes covered under another group benefit plan that does not have any exclusion or limitation with respect to preexisting conditions that would limit coverage for the qualified beneficiary;
7. The date the qualified beneficiary moves outside the state of California;
8. The date the employer ceases to provide any group benefits to employees;
9. The occurrence of any other event that justifies termination under the terms of the Group Agreement;
10. After January 1, 1999, employees who are 60 years or older when they become eligible for Cal-COBRA and have worked for the employer for at least five years may continue their coverage even after Cal-COBRA until they turn 65.

The administration of Cal-COBRA is primarily the responsibility of United Concordia. However, you may elect to administer your Cal-COBRA program.

This advertisement is not an offer of coverage or proposal of insurance. Dental plans are administered by United Concordia Companies, Inc., and underwritten by United Concordia Insurance Company, United Concordia Insurance Company of New York, United Concordia Dental Plans, Inc., United Concordia Dental Plans of California, Inc., United Concordia Dental Plans of the Midwest, Inc., United Concordia Dental Plans of Pennsylvania, Inc., and United Concordia Dental Plans of Texas, Inc. United Concordia policies are limited benefit policies covering dental benefits only. For a complete listing of the products and services available in your area; the specific UCCI company licensed to provide those products; and exclusions, limitations, renewal, cancellation and cost information, contact a United Concordia account representative or visit UnitedConcordia.com. Administrative and claims offices are located at 1800 Center Street, Suite 2B 220, Camp Hill, PA 17011 (888-884-8224).

United Concordia dental℠

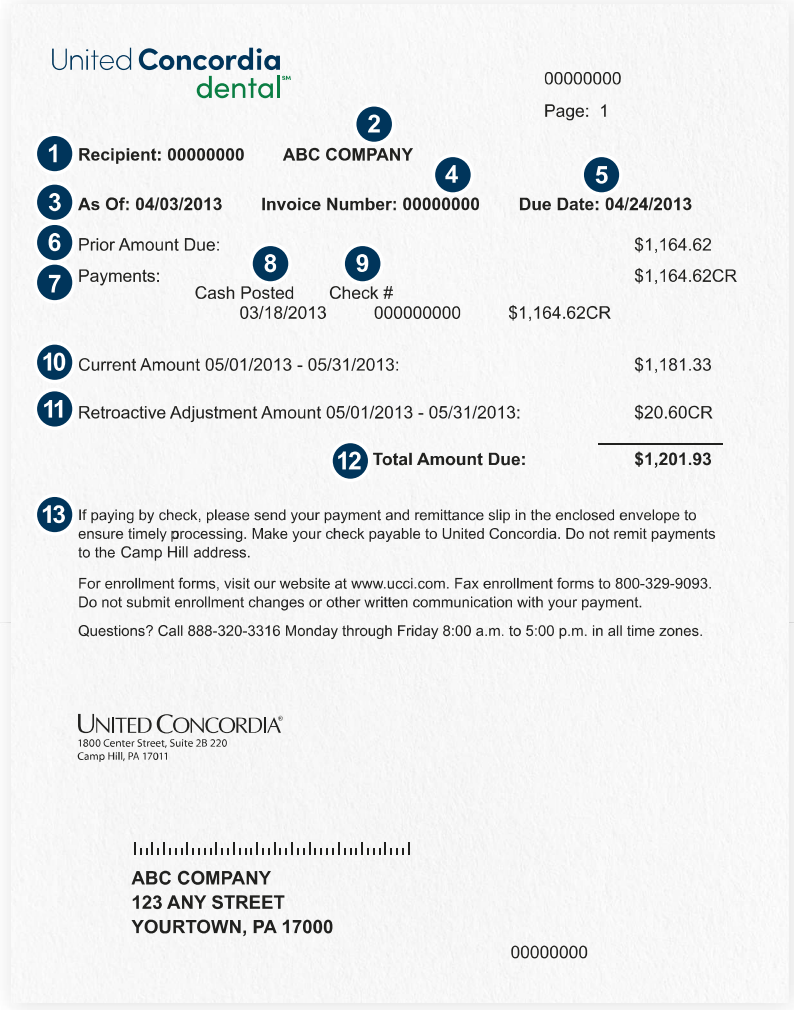
MX3347171

United Concordia dental℠



United Concordia's Invoice Guide

Combining online tools and personal service to make insurance easy.


United Concordia dental℠
00000000
Page: 1
1 Recipient: 00000000
2 ABC COMPANY
3 As Of: 04/03/2013
4 Invoice Number: 00000000
5 Due Date: 04/24/2013
6 Prior Amount Due: $1,164.62
7 Payments: $1,164.62CR
8 Cash Posted 03/18/2013
9 Check # 000000000
$1,164.62CR
10 Current Amount 05/01/2013 - 05/31/2013: $1,181.33
11 Retroactive Adjustment Amount 05/01/2013 - 05/31/2013: $20.60CR
12 Total Amount Due: $1,201.93
13 If paying by check, please send your payment and remittance slip in the enclosed envelope to ensure timely processing. Make your check payable to United Concordia. Do not remit payments to the Camp Hill address.
For enrollment forms, visit our website at www.ucci.com. Fax enrollment forms to 800-329-9093. Do not submit enrollment changes or other written communication with your payment.
Questions? Call 888-320-3316 Monday through Friday 8:00 a.m. to 5:00 p.m. in all time zones.
UNITED CONCORDIA®
1800 Center Street, Suite 2B 220
Camp Hill, PA 17011
ABC COMPANY
123 ANY STREET
YOURTOWN, PA 17000
00000000

United Concordia dental℠

00000000

Page: 3

1 **Recipient: 00000000** 2 **ABC COMPANY**

3 **As Of: 04/01/2013** 4 **Invoice Number: 00000000** 5 **Due Date: 04/23/2013**

6 Concordia Flex 10 Type Contract Summary:	7 Current Billed Amount 04/01/2013-04/31/2013	8 Retroactive Adjustment Billed Amount 02/01/2013-03/30/2013	9 Total Billed Amount
Individual	$597.40	$20.60	$618.00
Two Adults	$246.60	$0.00	$246.60
Family	$923.00	$0.00	$923.00
11 Total	**$1,767.00**	**$180.00CR**	**$1,787.60**

United Concordia dental℠

REMITTANCE

1 **Recipient: 00000000** **ABC COMPANY**

3 **Due Date: 06/27/2013**

4 Current Period: 06/01/2013-06/30/2013

5 Invoice Number: 0000000

Amount Due: $1,787.60 6

2 United Concordia
P.O. Box 00000
Anytown, PA 00000-0000

7 Amount Paid:

Please return this slip with your payment to ensure proper credit to your account.

Page: 1

04/01/2013 22.43.44 United Concordia Companies, Inc.
PA0000D-0000 Subscriber Detail Billing Report
Current Period and Adjustments

Recipient: 000 000000 000 ABC Company

Invoice Number: 00000000
Current Period: 04/01/2013 - 04/30/2013
Enrollment Maint Through: 04/01/2013 22.30.40

1 Identifcation Number	2 Name	3 Product Line	4 Type Contract	5 Eff Date	6 Cancel Date	7 Rate	8 Current Bill Period	9 Retro Adjust Bill Period	10 Total Billed Amount
000000000	Doe, John	Dental	Two Adults	01/01/2013		$26.00	---		$14.00
000000000	Doe, George	Dental	Individual	01/01/2013		$14.00	1.0	---	
000000000	Smith, Jennifer	Dental	Family	01/01/2013		$29.00	---	---	$40.00
000000000	Smith, Jane	Dental	Family	01/01/2013		$20.00	1.0	---	
000000000	Smith, Linda	Dental	Individual	01/01/2013		$20.00	1.0	---	
000000000	Johnston, Jeffery	Dental	Two Adults	01/01/2013		$19.00	---	---	$22.00
000000000	Johnston, Will	Dental	Family	01/01/2013	12/12/2012	$22.00	1.0	---	
000000000	Doe, George	Dental	Individual	01/01/2013		$14.00	1.0	---	
000000000	Smith, Jennifer	Dental	Family	01/01/2013		$21.00	---	---	$40.00
000000000	Smith, Jane	Dental	Family	01/01/2013		$20.00	1.0	---	
000000000	Smith, Linda	Dental	Individual	01/01/2013		$20.00	1.0	---	
000000000	Johnston, Jeffery	Dental	Two Adults	01/01/2013		$29.00	---	---	$22.00
000000000	Johnston, Will	Dental	Family	01/01/2013		$22.00	1.0	---	
11 Total For Individual							29.0	1.0	$618.00
Total For Two Adults							6.0		$246.00
Total For Family							13.0		$923.00
Total For 000 000000 000							14.0		$1,220.00
							62.0	1.0	$3,007.00



United Concordia dental℠

United Concordia dental℠



Make College More Affordable

Ease the stress of college debt

Financial stress and workplace performance are linked. Employees strapped with debt are less engaged and more distracted at work.[1]

We care about your employees' whole body health, which includes mental health. That's why United Concordia Dental plans include the College Tuition Benefit®, a savings program that could help you attract, retain and motivate employees — at no additional cost to you or your employees.

THE COLLEGE TUITION BENEFIT®

Advantages of the College Tuition Benefit

- ***A value-added feature*** – The College Tuition Benefit is automatically included in your dental plan.
- ***Round out your benefits package*** – Enrich employee benefits with a college savings program.
- ***Recruit and retain employees*** – Help alleviate a big financial worry for nearly 70% of families — how to pay for college.*
- ***Minimal work to implement*** – Enjoy the ease of a paperless process at **unitedconcordia.collegetuitionbenefit.com**.

How the program works

- 1 Tuition Rewards point = $1 in tuition discounts.
- Employees earn 2,000 points at sign-up, then 2,000 points each year they're covered by United Concordia.
- Points can be redeemed by the policyholder's children, grandchildren, nieces, nephews, stepchildren, godchildren and adopted children.
- Each child enrolled receives a one-time bonus of 500 Tuition Rewards points.

College costs burden families

Top financial concern
70% of American families stress about how to pay for college
(Discover Student Loans Survey; 2023.)

Second largest debt
Behind mortgage debt
(New York Federal Reserve; 2023.)

82% need financial aid
People who say aid will be very necessary
(Princeton Review, 2023.)

To learn more, talk to your United Concordia account representative or visit UnitedConcordia.com.

1 PwC; 2023 Employee Financial Wellness Survey; January 2023. *Discover Student Loans survey; 2023. Tuition Rewards® is a Registered Trademark of SAGE Scholars, Inc.

MX2870734 9/23 • ERC-0216-0320

PPO group dental plans are administered by United Concordia Companies, Inc., and underwritten by United Concordia Insurance Company and United Concordia Insurance Company of New York (collectively "UCCI"). Not all products available in all jurisdictions. For information about which companies are licensed in your state, visit the "Disclaimers" link at www.UnitedConcordia.com. Administrative and claims offices are located at 1800 Center Street, Suite 2B 220, Camp Hill, PA 17011 (888-884-8224). Policies have exclusions, limitations, and reduction of benefits which may affect benefits payable. Policies or their provisions may vary or be unavailable in some states. See the actual policy or your account representative for specific provisions and details of availability

SAGE is not a subsidiary or affiliate of UCCI. Subject to eligibility requirements and terms and conditions. Tuition Rewards are not an insured benefit, but instead a program offered through a Plan Sponsor Agreement with SAGE. Program participation subject to enrollment with SAGE. "Points" are credits that may be used to discount the cost of Tuition and have no cash value. UCCI does not provide services related to this program. Tuition Rewards not available in all jurisdictions. Program subject to change without notice. United Concordia makes no representations regarding tax laws or any tax consequences of this Program. Please consult your tax advisor regarding your tax situation.

Notice of Privacy Policies and Practices (HIPAA)

UNITED CONCORDIA® DENTAL

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Legal Duty

United Concordia Companies, Inc., and its subsidiaries (referred to as United Concordia) are committed to protecting your privacy and are required by applicable federal and state laws to maintain the privacy of your protected health information. "Protected health information" is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse, that relates to: (1) your past, present, or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

We are required to give you this notice about our privacy practices, which describes how we may use, disclose, collect, handle and protect our members' protected health information; our legal duties; and your rights concerning your protected health information. We are required to maintain the privacy of your protected health information and inform you of your right to be notified following a breach of your unsecured protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 9/23/2013 and will remain in effect until we replace it.

We will continually review our privacy practices to ensure the privacy of our members' protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this notice at any time, provided that changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices, and the new terms of our notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. If we make a significant change in our privacy practices, we will revise this notice and notify all affected members in advance of the change. Changes to this notice will be posted on our website, and we will provide you with either the revised notice or information about the changes and how to obtain a revised notice.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

In order to administer our benefit programs effectively, we collect, use and disclose protected health information for certain of our activities, including payment and health care operations. The following is a description of how we may use and/or disclose protected health information about you for payment and health care operations.

Payment and Health Care Operations: We may use and disclose your protected health information to pay claims for services provided to you by providers covered by your plan to: determine your eligibility for benefits, coordinate benefits, examine medical necessity, obtain premiums and/or issue explanations of benefits. We may use and disclose your protected health information to: conduct quality assessment and improvement activities, engage in care coordination or case management, manage our business and rate our risk and determine the premium for your health plan. However, we may not use or disclose your protected health information that is genetic information for underwriting purposes.
We may use and/or disclose your protected health information for all activities that are included within the definition of "payment" and "health care operations," but we have not listed all of the activities in this notice so please refer to 45 C.F.R. § 164.501 for a complete list.

Business Associates: In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf, or to provide certain types of services (such as member service support, utilization management or subrogation). To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

Other Covered Entities: In addition, we may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain of their health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

Other Possible Uses and Disclosures of Protected Health Information

In addition to uses and disclosures for payment and health care operations, we may use and/or disclose your protected health information for the following purposes.

To Plan Sponsors: We may disclose your protected health information and the protected health information of others enrolled in your group plan to the plan sponsor to perform plan administration functions. We may also disclose summary health information to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan, or to decide whether to modify, amend or terminate your group health plan. Please see your plan documents for a full explanation of the limited uses and disclosures that the plan sponsor may make of your protected health information in providing plan administration functions for your group plan.

Benefits and Services: We may use your protected health information to contact you with information about health-related benefits and services, or about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities.

Others Involved in Your Health Care: Unless you object, we may release protected health information about you to a friend or family member who is involved in your health care, or to someone who helps pay for your care. We may also disclose protected health information about you to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status or location.

Research, Death: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, medical examiner or funeral director.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the healthcare system, or government programs or its contractors, and to public health authorities for public health purposes. We may disclose your protected health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

Legal Proceedings and Enforcement: We may disclose your protected health information in response to a court or administrative proceeding or order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, we may disclose your protected health information to law enforcement official to locate or identify a suspect, fugitive, material witness, crime victim or missing person.

Inmates: If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official to provide health care to you, for your health and safety and the health and safety of others, or for the safety and security of the correctional institution.

Health Oversight Activities: We may disclose your protected health information to a health oversight agency for audits, investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions. Oversight agencies include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and compliance with civil rights laws.

Military and National Security: We may disclose to Military authorities the protected health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials protected health information required for lawful intelligence, counterintelligence and other national security activities.

Workers' Compensation: We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

To You and on Your Authorization: We must disclose your protected health information to you, as described in the Individual Rights section of this notice below. You may give us written permission to use your protected health information or to disclose it to anyone for any purpose. We may use or disclose to a business associate or to an institutionally related foundation, your protected health information for the purpose of raising funds on our behalf. With each fundraising communication we will provide you with the opportunity to elect not to receive any further fundraising communications. Uses and disclosures for marketing purposes, disclosures that constitute a sale of protected health information and other uses and disclosures not described within this notice will only be made with your written authorization. If you give us authorization, you may change your mind at any time. Your decision to revoke your prior authorization will not affect any use or disclosures made while it was in effect.

Individual Rights

Access: You have the right to inspect and copy protected health information about you in a designated record set that may be used to make decisions about your care. To inspect and copy protected health information, you must submit your request in writing to the Privacy Office. You may request that we provide copies in a format other than paper. We will use the format you request unless we cannot practicably do so.

We may charge a fee for the costs of copying, mailing or other costs associated with your request. We may deny your request to inspect and copy in certain limited circumstances. If your request is denied, you may request a review of that decision. Under certain conditions, our denial will not be reviewable and we will inform you of that with our decision. The healthcare professional conducting the review will not be the person who denied your initial request. We will comply with the outcome of the review.

Accounting: You have the right to receive a list of instances in which we disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities. Your request may be for disclosures made up to 6 years before the date of your request. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure and certain other information. The first list you request will be free. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact the Privacy Office for information on these fees.

Restriction: You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these restrictions. If we do, we will follow our agreement, unless the information is needed to provide emergency treatment to you. A request to restrict your protected health information, must be made in writing and must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. We will notify you if we end our agreement with you to restrict your protected health information.

Confidential Communications: If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. For example you may ask that we contact you only at your work address or via your work e-mail. Your request must be in writing and must state that the information could endanger you if it is not communicated in confidence by the alternative means or location you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may submit in writing a statement disagreeing with the denial, which we will add to the information you wanted to amend. If we accept your request, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Paper Copy of This Notice: You have the right to a paper copy of this notice, and you may ask us to give you a copy of this notice at any time. You may obtain an electronic copy of this notice on our website.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed below.

If you are concerned that we may have violated your privacy rights or you disagree with: (1) a decision we made about access to your protected health information, (2) our response to a request you made to amend or restrict the use or disclosure of your protected health information, or (3) our response to your request to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office:	United Concordia Privacy Dept.
Telephone:	(866) 215-2352 (Toll Free)
Fax:	(717) 260-7494
Website:	www.UnitedConcordia.com
Address:	1800 Center Street Suite 2B 220 Camp Hill, PA 17011

United Concordia Companies, Inc., and Subsidiaries
DHMO Plans:
KY, MD, NJ: United Concordia Dental Plans, Inc.
CA: United Concordia Dental Plans of California, Inc.
MI, MO, OH: United Concordia Dental Plans of the Midwest, Inc.
PA: United Concordia Dental Plans of Pennsylvania, Inc.
TX: United Concordia Dental Plans of Texas, Inc.
PPO Plans:
All states except NY: United Concordia Insurance Company
NY: United Concordia Insurance Company of New York

United Concordia dental℠

Notice of Privacy Policy for Consumer Nonpublic Personal Information

(GRAMM-LEACH-BLILEY)

Please read this notice carefully, it contains important information on our privacy policy.

United Concordia values our customers and takes privacy seriously. In order to administer our benefits programs effectively, we must collect, use and disclose nonpublic personal information (NPPI). NPPI means nonpublic personal financial information and non-public personal health information. NPPI is information that identifies an individual member of a United Concordia program. It may include an individual's name, address, telephone number and social security number, or it may relate to an individual's participation in the plan, his/her health condition, the provision of health care services or the payment of health care services. NPPI does not include publicly available information, or information available or reported in an aggregate form that does not identify individual persons.

We are committed to protecting the privacy and confidentiality of this information. We will inform our customers of our policy on collecting, using, sharing and securing NPPI the first time you become a customer and annually reaffirm our privacy policy. We will continually review our privacy policy, and monitor our business practices to help ensure the security of member NPPI. Should a change to our privacy policy be required, we will notify our customers in writing and in advance of the change.

Information we may collect on members and their dependents:

The NPPI we collect varies, depending upon the products and services requested. We collect NPPI from the following sources:

- Information we receive directly or indirectly from the member or the member's group or administrator through applications, surveys or other forms, in writing, in person, by telephone or electronically. Information including, but not limited to name, address, social security number, date of birth, marital status, dependent information, employment information and health history.
- Information about a member's relationship and transactions with our affiliates, our agents, others and us. This may include information on claims, eligibility, health conditions, health history, utilization review, appeals, grievances, payments and other financial information, including personal financial information.

Member information we may disclose and the purpose:

We do not disclose any NPPI about members or former members to anyone, except as permitted or required by law. Disclosures may be made without prior authorization as permitted by law. We use NPPI internally, share NPPI with our affiliates, and disclose NPPI to health care providers, agents, other insurers, payors, vendors, consultants and government authorities as necessary to administer benefit policies or contracts, to detect and/or prevent insurance fraud and to comply with mandatory regulatory activities. We contractually require any person or organization providing services or products on our behalf to protect the confidentiality of our customers' and members' NPPI.

Safeguarding member NPPI:

We restrict access to NPPI about members and their dependents to those employees, vendors, healthcare providers and agents who need to know that information to provide products or services. We maintain physical, electronic and procedural safeguards that comply with state and federal regulations to guard member NPPI from unauthorized access, use and disclosure.

Coverage may be underwritten or administered by one or more of the following subsidiaries of United Concordia Companies, Inc.:

United Concordia Dental Corporation of Alabama

United Concordia Dental Plans of California, Inc.

United Concordia Dental Plans, Inc.

United Concordia Dental Plans of Kentucky, Inc.

United Concordia Dental Plans of the Midwest, Inc.

United Concordia Dental Plans of Pennsylvania, Inc.

United Concordia Dental Plans of Texas, Inc.

United Concordia Insurance Company

United Concordia Insurance Company of New York

United Concordia Life and Health Insurance Company

United Concordia dental℠

TO: Group Administrator

FROM: United Concordia

RE: Continuity of Health Care Notice

Please distribute the enclosed Continuity of Health Care Notice to any employee that is a resident in the state of Maryland. The notice needs to be distributed immediately upon receipt.

Thank you.

United Concordia
Continuity of Health Care Notice

You are receiving this notice because you are a new enrollee and may be moving from Maryland Medical Assistance or another company's health benefit plan or dental plan to United Concordia coverage. If you currently are receiving treatment, you have special rights in Maryland.

For example, if your old company gave you pre-approval to have surgery or to receive other services, you may not need to receive new approval from us to proceed with the surgery or to continue receiving the same services. Also, if you are seeing a doctor or other health care provider who is an in-network provider with your old company, and that provider is not an in-network provider under your new plan, you may continue to see your provider for a limited period of time as though the provider were an in-network provider with us.

The rules on how you can qualify for these special rights are described below.

Prior approval for health care or dental services.

- If you previously were covered under another company's plan, a prior approval (also called "preauthorization") for services that you received under your old plan may be used to satisfy a prior approval requirement for those services if they are covered under your new plan with us.

- **To be able to use the old prior approval under this new plan, you will need to contact us at United Concordia, Dental Customer Service, P. O. Box 69420, Harrisburg, PA 17106-9420 to let us know that you have a prior approval for the services and provide us with a copy of the prior approval.** Your parent, guardian, designee, or health care provider may also contact us on your behalf about prior approval.

- There is a time limit for how long you can rely on the prior approval. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date your coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health care practitioner after the baby is born.

- *Limitation on Use of Prior Approvals:* If your prior approval was for benefits or services provided through the Maryland Medical Assistance fee-for-service program, you may not use the prior approval unless it is for behavioral health or dental benefits authorized by a third-party administrator.

- If you do not have a copy of the prior approval, contact your old company and request a copy. Under Maryland law, your old company must provide a copy of the prior approval within 10 days of your request.

Right to use non-network providers.

- If you have been receiving services from a health care provider who was an in-network provider with your old company, and that provider is a non-network provider under your new health plan with us, you

may be able to continue to see your provider as though the provider were an in-network provider. You must contact us at United Concordia, Dental Customer Service, P. O. Box 69420, Harrisburg, PA 17106-9420 to request the right to continue to see the non-network provider with us. Your parent, guardian, designee, or health care provider may also contact us on your behalf to request the right for you to continue to see the non-network provider.

- This right applies if you are being treated by the non-network provider for covered services for one or more of the following types of conditions:

    1. Acute conditions (including acute dental conditions);
    2. Serious chronic conditions (including serious chronic dental conditions);
    3. Pregnancy;
    4. Mental health conditions;
    5. Substance use disorders; or
    6. Any other condition upon which we and the out-of-network provider agree.

- Examples of the conditions listed above include bone fractures, joint replacements, heart attacks, cancer, HIV/AIDS and organ transplants.

- There is a time limit for how long you can continue to see a non-network provider and only need to pay cost-sharing as though the provider were an in-network provider. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date your coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health care practitioner after the baby is born.

Limitation: With regard to dental benefits, the special rights described in this notice apply only to covered services for which a coordinated treatment plan is in progress.

Appeal Rights:

- If we deny your right to use a prior approval from your old company or your right to continue to see a provider who was an in-network provider with your old company, you may appeal this denial by contacting us at United Concordia, Dental Customer Service, P. O. Box 69420, Harrisburg, PA, 17106-9420.

- If we deny your appeal, you may file a complaint with the Maryland Insurance Administration. To receive a complaint form from the Maryland Insurance Administration call 1-800-492-6116, select option 3, then option 2 or download a complaint from the Maryland Insurance Administration's website at www.mdinsurance.state.md.us.

- If you have any questions about this notice, please contact us at 1-800-332-0366.

The Group Insurance Policy begins on the next page

GROUP INSURANCE POLICY
for
Dental Benefits

United Concordia Insurance Company
1800 Center Street, Suite 2B 220
Camp Hill, PA 17011

Policyholder: EFFINGHAM COUNTY BOARD OF EDUCATION

Group Number(s): 926682000, 926682001, 926682002, 926682003, 926682004, 926682005, 926682006, 926682007, 926682008, 926682009, 926682010, 926682011, 926682099, 926682199, 926682299, 926682399, 926682499, 926682599

Effective Date: January 1, 2025

Minimum Participation Required: 70% enrolled

Term: 24 months

Advance Renewal or Non-Renewal Notice: 150 days

Advance Amendment Notice: 31 days

This is a Family Policy

The Policyholder and United Concordia Insurance Company ("Company") will make the dental benefit plan available to eligible Certificate Holder(s) of the Policyholder and/or their Dependents ("Members") at 12:01 AM on the Effective Date and upon the terms and conditions contained in this Group Insurance Policy (Group Policy). The Company will pay the benefits described in the Certificate of Insurance (hereinafter referred to as "Certificate") and any schedules, amendments, endorsements or riders attached thereto, subject to the Group Policy terms. The parties shall fulfill the obligations stated herein.

Certain terms in this Group Policy have specific meanings as set forth in the Definitions section of the Certificate which is attached and incorporated herein by this reference.

AGREEMENT AND CONSIDERATION: In consideration of payment of all Premiums when due and receipt of accurate and complete application information, the Company will insure those Members enrolled in the Policyholder's Group Policy for dental benefits in accordance with the terms and conditions of this Group Policy. Coverage will begin at 12:01 AM on the Effective Date shown above. It will remain in force until the first Renewal Date, and for such further periods for which it is renewed.

INSURANCE RULES

A. Eligibility:

In order to be eligible to enroll for benefits under this Group Policy, a Certificate Holder and any Dependents must meet the Policyholder's eligibility requirements, satisfy the requirements and definitions set forth in the Certificate.

No person who meets the eligibility requirements of this Group Policy shall be refused enrollment or re-enrollment because of age, race, color, national origin, disability, sexual orientation, gender identity, sex, dental health status, genetic disorder, or the existence of a pre-existing dental condition.

B. Enrollment:

Eligible Certificate Holders and/or their eligible Dependent(s) shall become enrolled under the Group Policy as set forth in the Certificate and the Policyholder Obligations section of this Group Policy. An open enrollment period may be provided in which Certificate Holders may elect to enroll or disenroll themselves and eligible Dependents under this Group Policy. Open enrollment occurs at a time and frequency stipulated by the Company subject to the request of the Policyholder or its authorized representative.

GENERAL POLICY 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. The Company reserves the right to seek reimbursement from the Policyholder for any bank charges incurred for insufficient funds on a payment by the Policyholder.

B. Term of Group Policy:

This Group Policy shall begin at 12:01 A.M. on the Effective Date, continue in effect for the initial term shown on the first page of this Group Policy and renew thereafter for terms indicated in the Group Policy renewal notices, subject to the following:

1) Either the Policyholder or the Company may elect not to renew the Group Policy by providing due and proper notice in accordance with the advance renewal notice indicated on the first page of this Group Policy. In the absence of notice from the Policyholder of its intention not to renew, receipt of the renewal Premium constitutes the Policyholder's acceptance of the renewal. In the event of non-renewal by the Policyholder, any unpaid Premium due for months prior to the termination shall be due and payable on the Termination Date.

2) The Company may terminate this Group Policy upon default in the payment of Premium by giving to the Policyholder thirty-one (31) days prior written notice of such termination or nonrenewal. Notice to the Policyholder shall state the amount of Premium due and the Grace Period for payment. Payment of said sum prior to the date of intended termination shall continue this Group Policy in full force and effect. If payment is not remitted by the end of the Grace Period, the Group Policy will terminate and coverage will end at the conclusion of the period for which the last Premium payment was made. During the Grace Period, coverage shall continue in effect regardless of non-payment of Premium. The Policyholder shall remain liable to the Company for Premiums accrued during the Grace Period. For purposes of this section, the Company will apply these default provisions to any separate billing locations of the Policyholder when the Policyholder elects to structure its Group with separate billing locations that are independently responsible for Premium payment.

3) The Company may terminate this Group Policy with thirty-one (31) days advance notice if the number of Certificate Holders enrolled under this Group Policy totals less than the minimum participation required on the first page of this Group Policy.

4) The Company may also adjust the Premium or benefits with thirty-one (31) days advance notice if the number of Certificate holders enrolled under this Group Policy increases or decreases by 10% or if the extent or nature of the risk changes significantly.

5) The Group Policy or coverage of a Member may be terminated immediately when there is fraud or misrepresentation by the Policyholder or Member respectively.

6) Notwithstanding the above provisions, either the Company or the Policyholder may terminate this Group Policy with at least 60 days advance written notice. Any unpaid Premium due for months prior to the termination shall be due and payable on the Termination Date.

C. Policyholder Obligations:

The Policyholder agrees, in addition to any other obligations contained herein, that it or its authorized representative shall:

1) Define its eligibility requirements for enrollment of Members under the Group Policy and communicate such requirements, including any changes, to Members. During the term of this Group Policy, no change in the Policyholder'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.

2) Collect from its Certificate Holders any contribution toward the Premium and notify Certificate Holders of any change in such contribution. Pay in full when due the Premium specified on the Schedule of Premium or renewal notice for this Group Policy for all enrolled Certificate Holders and Dependents, as reported to the Company. Unless otherwise agreed between the Policyholder and the Company or dictated by applicable law or regulation, Premium for Members who become ineligible during the course of this Group Policy is due through the end of such month in which they become ineligible.

3) At a mutually agreed upon time, provide accurate and timely enrollment data including additions, terminations and changes required by the Company to perform its duties under this Group Policy and to determine Premium rates. The Policyholder will be held liable for the cost of claims incurred as a result of inaccurate enrollment data, or retroactive terminations of enrollment that exceed the guidelines of the Company. All records of the Policyholder that bear on the insurance 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 Policyholder.

4) 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 Policyholder's obligation to notify Certificate Holders and Dependents of their rights and any Premium due for continuation coverage as required by law.

5) Notify all Certificate Holders of the termination of the Group Policy. Coverage will be terminated regardless of whether the notice is given.

D. Company Obligations:

The Company or its authorized representative shall perform administrative functions necessary to ensure the provision of benefits for the Policyholder and its Members. Such functions may include, but are not limited to billing, processing claims, providing a Certificate of Insurance for Certificate Holders, responding to inquiries and complaints related to this Group Policy, and maintaining records.

The Company does not disclose claim or eligibility records except 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. Claim records are owned by and are proprietary to the Company.

E. General Provisions:

1) This Group Policy shall be governed by the laws of the state where the Group Policy is issued and delivered.

2) This Group Policy consists of the attached Application for Group Dental Insurance, Schedule of Premium, Certificate of Insurance, Schedule of Exclusions and Limitations, Schedule of Benefits, and, any riders, addenda and/or endorsements to the previously mentioned forms and represents the entire agreement between the Policyholder and the Company with respect to the subject matter. The failure of any section or subsection of this Group Policy shall not affect the validity, legality and enforceability of the remaining sections hereof. A copy of the Application shall be attached to the Group Policy when issued.

3) The provisions of the Certificate of Insurance and all of its schedules, endorsements, addenda and riders, and all schedules, endorsements, addenda and riders issued to amend this Group Policy after its Effective Date are made a part of this Group Policy.

4) No statement of the Policyholder shall be used in any contest of the insurance under this Group Policy. There will be no contest of the validity of the Group Policy, except for not paying Premiums, after it has been in force two (2) years after the Effective date. All statements, made by the Policyholder 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 Policyholder. 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.

5) Except as otherwise herein provided, each amendment to this Group Policy, including a change in the Premium or benefits shall be proposed by the Company to the Policyholder at renewal and in writing with the advance renewal notice indicated on the first page of this Group Policy. Except as otherwise provided herein, each amendment shall become effective on the date this Group Policy renews in accordance with General Policy Rules (B).

6) An amendment mutually agreed to by both parties can be proposed at any time by either party in writing to the other with the advance notice indicated on the first page of this Group Policy. The effective date must be mutually agreed to by both parties. Payment of Premium will confirm acceptance of amendment. A change in the Group Policy may be made at any time without mutual agreement of the parties if the change is either necessary to satisfy the requirements of any state or federal law applicable to the Group Policy or to accommodate changes in Current Dental Terminology©. An amendment will not affect a claim incurred prior to the effective date of the change.

7) Only a duly designated officer of the Company has the authority to: (a) waive any conditions or restrictions of the Group Policy; (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 such authority.

8) Notices to the Company shall be sent to:

United Concordia Insurance Company
1800 Center Street, Suite 2B 220
Camp Hill, PA 17011
800-332-0366

SCHEDULE OF PREMIUM – PROSPECTIVE RATING METHOD

Group Number(s): 926682000, 926682001, 926682006, 926682007, 926682099, 926682399

The Premium is determined from the monthly rates multiplied by the number of enrolled Certificate Holders and/or Dependents as described below.

Premium stated below for the Policyholder's Certificate Holders is due as specified on each notice of Premium and is guaranteed for the term stated below.

The Premium rates are guaranteed for the period from January 1, 2025 to December 31, 2026.

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

Rating Tier	Rate ($)
Certificate Holder Only	$32.26
Certificate Holder/Spouse	$52.67
Certificate Holder/Child(ren) - all ages	$39.39
Family, including children of all ages	$88.19

SCHEDULE OF PREMIUM – PROSPECTIVE RATING METHOD

Group Number(s): 926682002, 926682003, 926682008, 926682009, 926682199, 926682499

The Premium is determined from the monthly rates multiplied by the number of enrolled Certificate Holders and/or Dependents as described below.

Premium stated below for the Policyholder's Certificate Holders is due as specified on each notice of Premium and is guaranteed for the term stated below.

The Premium rates are guaranteed for the period from January 1, 2025 to December 31, 2026.

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

Rating Tier	Rate ($)
Certificate Holder Only	$47.51
Certificate Holder/Spouse	$76.61
Certificate Holder/Child(ren) - all ages	$57.26
Family, including children of all ages	$128.27

SCHEDULE OF PREMIUM – PROSPECTIVE RATING METHOD

Group Number(s): 926682004, 926682005, 926682010, 926682011, 926682299, 926682599

The Premium is determined from the monthly rates multiplied by the number of enrolled Certificate Holders and/or Dependents as described below.

Premium stated below for the Policyholder's Certificate Holders is due as specified on each notice of Premium and is guaranteed for the term stated below.

The Premium rates are guaranteed for the period from January 1, 2025 to December 31, 2026.

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

Rating Tier	Rate ($)
Certificate Holder Only	$60.67
Certificate Holder/Spouse	$97.29
Certificate Holder/Child(ren) - all ages	$85.59
Family, including children of all ages	$183.30

Docusign Envelope ID: 7FAA0099-9472-4EE5-9455-433AB96CCCB6

UNITED CONCORDIA

APPLICATION FOR GROUP DENTAL INSURANCE

GROUP'S LEGAL NAME AND ADDRESS:

Name: Effingham County Board of Education Address: 405 N Ash Street, Springfield, GA 31329

For general correspondence, receipt of billings and certificates: (If address is different than noted, place contact address on back)

Policymaker Name: Dr. Kirbi Ratner Title: Assistant Superintendent for HR

Address: 405 N Ash Street, Springfield, GA 31329

Phone #: 912-754-1119 Fax #: Email: kratner@effingham.k12.ga.us

Group Administrator: Mark Rahn, srahn@effingham.k12.ga.us Marketing Relationship: Payroll & Benefits Administrator

Phone #: 912-754-2512 Fax #:

PRODUCTS SELECTED: ***Please attach quote/proposal with product and rates marked.***

■ PPO ☐ DHMO ☐ Indemnity Fee-for-Service

PARTICIPATION SUMMARY:

2254 # Eligible employees
1418 # Enrolled
836 # Waived
____ # Spouse Opt-Outs

GROUP EFFECTIVE DATE:

(1st of month) 01 / 01 / 25

PRIOR COVERAGE: Yes ■ No ☐

Carrier MetLife

RATE PERIOD:

(MM/DD/YYYY)

From 01/01/25 (1st of month) 12:01 AM

To 12/31/26 (Last day of month) 12:00 AM

ELIGIBILITY WAITING PERIOD:

New Certificate Holders are eligible for coverage on the 1st of the month following 30 days/mos in an eligible class, or other: _____

COVERAGE INCLUDES:

■ Employee
■ Spouse
☐ Domestic Partner
■ Children to Age 19
■ Children Age 19 to 26
☐ Students only, or
■ All

THE APPLICANT REPRESENTS that: by signing this application, he/she agrees that the group dental insurance described above will become effective upon acceptance of this application by United Concordia (UC). Application will be returned if quote is not attached. Applicant further acknowledges that no coverage will be effective before the date determined by UC and only if the first Premium has been paid and underwriting bid qualifications are met. If this application is accepted, it becomes a part of the insurance contract between Applicant and UC. If this application is not accepted, any Premium advanced by the Applicant will be refunded. Applicant warrants that all information on this application is true and complete, and acknowledges that coverage may be rescinded if there are material misstatements on this application. If errors or omissions in this application are discovered by UC, it is authorized to amend this application by noting the changes on this form, and the acceptance, evidenced by Premium payment, of any Policy issued on this application, so amended, shall constitute a ratification of any such changes or amendments. Upon policy renewal date, payment of the renewal premium will confirm acceptance of that renewal for the subsequent rate period. No agent or broker has the right to accept this application or bind coverage. Any first premium or application submitted to UC or its sales personnel by a non-appointed producer must be accompanied by completed appointment paperwork or it will be returned to the non-appointed producer.

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

Applicant Signature: Dr. Kirbi Ratner Date: 9/26/2024

Title: Assistant Superintendent for HR

Producer: Annette Griffin UCD Producer ID #: 105499

Agency: DS-BSC, LLC DBA Totem Solutions UCD Agency ID #: 105498

United Concordia programs are underwritten by the following companies in the listed states:

DENTAL HMO PRODUCTS:

United Concordia Dental Plans, Inc. - KY, MD, NJ
United Concordia Dental Plans of California, Inc. - CA
United Concordia Dental Plans of the Midwest, Inc. - MI, MO, OH
United Concordia Dental Plans of Pennsylvania, Inc. - PA
United Concordia Dental Plans of Texas, Inc. - TX

DENTAL PPO OR INDEMNITY PRODUCTS:

United Concordia Insurance Company - AK, AL, AR, AZ, CA, CO, CT, DE, DC, FL, GA, HI, IL, IA, ID, IN, KS, KY, LA, MA, ME, MD, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WV, WY
United Concordia Insurance Company of New York - NY

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

The Plan:

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

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

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

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

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

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

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-332-0366 (TTY: 711).
Español (Spanish)	ATENCIÓN: Si habla español, le ofrecemos servicios gratuitos de asistencia lingüística. Llame al 1-800-332-0366 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-0366 (TTY: 711)。
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-800-332-0366 (TTY: 711).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-0366 (TTY: 711) 번으로 전화해 주십시오.
Tagalog (Tagalog - Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-332-0366 (TTY: 711).
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните 1-800-332-0366 (телетайп: 711).
العربية (Arabic)	يرجى الانتباه: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة للغوية المجانية. اتصل على 1-800-332-0366 (TTY: 711)
Kreyòl Ayisyen (French Creole)	ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis èd nan lang ki disponib gratis pou ou. Rele nimewo 1-800-332-0366 (TTY: 711).
Français (French)	ATTENTION : si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Appelez le 1-800-332-0366 (ATS: 711).
Polski (Polish)	UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-0366 (TTY: 711).
Português (Portuguese)	ATENÇÃO: se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-800-332-0366 (TTY: 711).
Italiano (Italian)	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-332-0366 (TTY: 711).
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Dienste für die sprachliche Unterstützung zur Verfügung. Rufnummer: 1-800-332-0366 (TTY: 711).
日本語 (Japanese)	注意事項：日本語をお使いの方は、言語面でのサポートを無償でご利用いただけます。1-800-332-0366（TTY: 711）まで、お電話にてご連絡ください。
فارسی (Farsi)	توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید. 1-800-332-0366 (TTY: 711)

United Concordia dental℠

UNITED CONCORDIA INSURANCE COMPANY

1800 Center Street, Suite 2B 220
Camp Hill, PA 17011

Dental Plan
Certificate of Insurance

EFFINGHAM COUNTY BOARD OF EDUCATION
926682002, 926682003, 926682008, 926682009, 926682199, 926682499
January 1, 2025

United Concordia Dental policies are underwritten by
United Concordia Insurance Company

CERTFICATE OF INSURANCE

INTRODUCTION

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

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

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

800-332-0366

For general information, Participating Dentist or benefit information, You may also log on to our website at:

www.unitedconcordia.com

Claim forms should be sent to:

United Concordia Companies, Inc.
Dental Claims
PO Box 69421
Harrisburg, PA 17106-9421

TABLE OF CONTENTS

DEFINITIONS 4
ELIGIBILITY AND ENROLLMENT 6
HOW THE DENTAL PLAN WORKS 8
BENEFITS 9
TERMINATION 12
CONTINUATION OF COVERAGE 13
GENERAL PROVISIONS 13

Attached:

Appeal Procedure Addendum
Schedule of Benefits
Schedule of Exclusions and Limitations

DEFINITIONS

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

Annual Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during a calendar year or Contract Year as shown on the Schedule of Benefits. When a Member reaches the Annual Maximum, the Company will make no additional payment(s) for Covered Services.

Certificate Holder(s) - An individual who, because of his/her status with the Policyholder, has enrolled him/herself and/or his/her eligible Dependents for dental coverage and for whom Premiums are paid.

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

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

Company - United Concordia, the insurer.

Contract Year- The period of twelve (12) months beginning on the Group Policy's Effective Date or the anniversary of the Group Policy's Effective Date and ending on the day before the Renewal Date.

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

Cosmetic - Services or procedures that are not Dentally Necessary and are primarily intended to improve or otherwise modify the Member's appearance.

Covered Service(s) - Services or procedures shown on the Schedule of Benefits for which benefits will be covered subject to the Schedule of Exclusions and Limitations, when rendered by a Dentist.

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

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

Dentist(s) – A person licensed to practice dentistry in the state in which dental services are provided. Dentist will include any other duly licensed dental professional practicing under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

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

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

1. The Certificate Holder's Spouse and
2. Any natural child, stepchild, adopted child or child placed with the Certificate Holder or the Certificate Holder's Spouse by order of a court or administrative agency:
   (a) until the end of the month that the child reaches age twenty-six (26); or

(b) until the end of the month that the child reaches age twenty-six (26) if he/she is a full-time student at an accredited educational institution and is chiefly reliant upon the Certificate Holder for maintenance and support; or
(c) to any age if the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

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

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

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

Family Policy – A Group Policy that covers the Policyholder's Certificate Holders and may also cover eligible Dependents, as defined in this Certificate. A Group Policy that covers only Certificate Holders is not a Family Policy.

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

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

Lifetime Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during the entire time the Member is enrolled under the Group Policy, as shown on the Schedule of Benefits.

Limitation(s) - The maximum frequency or age limit applied to a Covered Service set forth in the Schedule of Exclusions and Limitations.

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 Us and the particular Participating Dentist rendering the service. Depending upon the Plan purchased by the Policyholder, Maximum Allowable Charges for Covered Services rendered by Non-Participating Dentists may be the same or higher than such charges for Covered Services rendered by Participating Dentists in order to help limit Out-of-Pocket Expenses of Members choosing Non-Participating Dentists.

Member(s) – Enrolled Certificate Holder(s) and their enrolled Dependent(s). Also referred to as "You" or "Your" or "Yourself".

Non-Participating Dentist - A Dentist who has not signed a contract with Us to accept the Company's Maximum Allowable Charges as payment in full for Covered Services.

Out-of-Pocket Expense(s) – Costs not paid by Us, including but not limited to Coinsurance, Deductibles, amounts billed by Non-Participating Dentists that are over the Maximum Allowable Charge, costs of services that exceed the Policy's Limitations or Maximums, or for services that are Exclusions. The Certificate Holder is responsible to pay for Out-of-Pocket Expenses.

Participating Dentist - A Dentist who has executed a Participating Dentist Agreement with Us, under which he/she agrees to accept the Company's Maximum Allowable Charges as payment in full for Covered Services. Participating Dentists may also agree to limit their charges for any other services delivered to Members.

Plan - Dental benefits pursuant to this Certificate and attached Schedule of Exclusions and Limitations and Schedule of Benefits.

Policyholder - Organization that executes the Group Policy. Also referred to as "Your Group".

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

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

Schedule of Benefits - Attached summary of Covered Services, Coinsurances, Deductibles, Waiting Periods and maximums applicable to benefits payable under the Plan.

Schedule of Exclusions and Limitations – Attached list of Exclusions and Limitations applicable to benefits, services, supplies or charges under the Plan.

Special Enrollment Period – The period of time outside Your Group's open enrollment period during which eligible individuals who experience certain qualifying events may enroll as Certificate Holders or Dependents in this Group Policy.

Spouse – The Certificate Holder's partner by marriage or by any union between two adults that is recognized by law in the state where this Group Policy is issued.

Teledentistry/Telehealth dental service – A health care service performed by a dentist, or appropriately licensed health care provider acting under the delegation and supervision of a dentist, to a patient who is at a physical location different than the provider using telecommunications or information technology.

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

Waiting Period(s) - A period of time a Member must be enrolled under the Group Policy before benefits will be paid for certain Covered Services as shown on the attached Schedule of Benefits.

We, Our or Us - The Company, its affiliate or an organization with which it contracts for a provider network and/or to perform certain functions to administer this Policy.

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

In order to be a Member, You must meet the eligibility requirements of Your Group and this Group Policy. We must receive enrollment information for the Certificate Holder, enrolled Dependents, and Policyholder. Provided that We receive applicable Premium, coverage will begin on the date specified in the enrollment information We receive. Your Group will inform Certificate Holders of its eligibility requirements.

If You have already satisfied all eligibility requirements on the Group Policy Effective Date and Your enrollment information and applicable Premium are supplied to Us, Your coverage will begin on the Group Policy Effective Date.

If You are not eligible to be a Member on the Group Policy Effective Date, You must supply the required enrollment information on Yourself and any eligible Dependents, as specified in the Definitions section, within thirty-one (31) days of the date You meet all applicable eligibility requirements.

Coverage for Members enrolling after the Group Policy Effective Date 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 teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. Procedures started prior to the Member's Effective Date are the liability of the Member or a prior insurance carrier.

Special Enrollment Periods - Enrollment Changes

After Your Effective Date, You can change Your enrollment during Your Group's open enrollment period. There are also Special Enrollment Periods when the Certificate Holder may add or remove Dependents. These Special Enrollment Period life change events include:

- birth of a child;
- adoption of a child;
- court order of placement or custody of a child;
- change in student status for a child;
- loss of other coverage; or,
- marriage or other lawful union between two adults.

If You enrolled through Your Group, to enroll a new Dependent as a result of one of these events, You must supply the required enrollment change information within the Special Enrollment Period that is thirty-one (31) days from the date of the life change event. The Dependent must meet the definition of Dependent applicable to this Group Policy.

Except for newly born or adoptive children, coverage for the new Dependent will begin on the date specified in the enrollment information provided to as long as the Premium is paid.

Newly born children of a Member will be considered enrolled from the moment of birth. Adoptive children will be considered enrolled from the date of adoption or placement, except for those adopted or placed within thirty-one (31) days of birth who will be considered enrolled Dependents from the moment of birth. In order for coverage of newly born or adoptive children to continue beyond the first thirty-one (31) day period, the child's enrollment information must be provided to Us and the required Premium must be paid within the first thirty-one (31) day period in which coverage is effective.

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 ninety (90) days after the child 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 thirty (30) days after the child 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 thirty (30) days after the Dependent attains the limiting age for students. Such evidence will be requested thereafter based on information provided by the Member's physician, but no more frequently than annually.

Dependent coverage may only be terminated when certain life change events occur including death, divorce or dissolution of the union or domestic partnership, reaching the limiting age or during open enrollment periods or when otherwise permitted by any applicable law or regulation.

Late Enrollment

If You or Your Dependents are not enrolled within thirty-one (31) days of initial eligibility or during the Special Enrollment Period specified for a life change event, You or Your Dependents cannot enroll until the next Special Enrollment Period or open enrollment period conducted for Your Group. If You are required by court order to provide coverage for a Dependent child, You will be permitted to enroll the Dependent child without regard to enrollment season restrictions.

HOW THE DENTAL PLAN WORKS

Choice of Provider

You may choose any licensed Dentist for services. However, Your Out-of-Pocket Expenses will vary depending upon whether or not Your Dentist is in Our network. If You choose a Participating Dentist, You may limit Your Out-of-Pocket Expense. Participating Dentists agree by contract to accept Maximum Allowable Charges as payment in full for Covered Services. Also, if agreed by the provider, Participating Dentists limit their charges for all services delivered to Members, even if the service is not covered for any reason and a benefit is not paid under this Plan. Participating Dentists also complete and send claims directly to Us for processing. To find a Participating Dentist, visit Our website at www.unitedconcordia.com or call Us at the toll-free number in the Introduction section of this Certificate or on Your ID card.

If You use a Non-Participating Dentist, You may have to pay the Dentist at the time of service, complete and submit Your own claims and wait for Us to reimburse You. You will be responsible for the Dentist's full charge which may exceed Our Maximum Allowable Charge and result in higher Out-of-Pocket Expenses.

Notice of Claims

Written notice of claim must be given to the Company within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Member to the Company, or to any authorized agent of the Company, with information sufficient to identify the Member, shall be deemed notice to the Company.

Claim Forms

The Company, upon receipt of a notice of claim, will furnish to the Member such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 10 days after the Company received notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

The Company will provide claim forms to and accept claims for filing proof of loss submitted by a custodial parent of an eligible Dependent child who is the subject of a court or administrative order relating to provision of health care coverage. If services are provided by a Non-Participating Dentist, the Company will make payments directly to such custodial parent or to the Department of Public Welfare if benefits are payable under Medical Assistance.

Proof of Loss

Written proof of loss must be furnished to the Company at its said office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 30 days after the termination of the period for which the Company is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

The acknowledgment by the Company of the receipt of notice given or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the Company in defense of any claim arising under such policy.

Time Payment of Claims

All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid no later than 30 days and acknowledge no later than 15 days from receipt of due written proof of such loss. The Company may extend this 30-day period by no more than 15 days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Company. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid quarterly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. Benefits not paid in accordance with this provision, Company shall pay 18 percent per annum on the proceeds overdue under the Plan for benefits not paid in accordance with this provision.

Physical Examinations

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

BENEFITS

Covered Services

Benefits and any applicable Coinsurance, Deductibles, Annual Maximums, Lifetime Maximums, Out-of-Pocket Maximums and Waiting Periods are shown on the attached Schedule of Benefits. Covered Services shown on the Schedule of Benefits must be Dentally Necessary unless otherwise specified in a Rider to this Group Policy and are subject to frequency or age Limitations detailed on the attached Schedule of Exclusions and Limitations.

No benefits will be paid for services, supplies or charges detailed under the Exclusions on the Schedule of Exclusions and Limitations, and no benefits will be paid for services on the Schedule of Benefits with a Coinsurance of zero (0).

TeleDentistry

Covered Services provided through Teledentistry are reimbursed on the same basis and to the same extent as coverage for the services provided in an in-person setting. Coverage is without regard to whether the service is provided in an in-person setting or virtually (i.e. through teledentistry). Covered Services provided through teledentistry accumulate to Your Annual Maximum, Deductible and frequency limitations, as applicable.

In order to receive Covered Services in a virtual setting, You will need an internet-ready device capable of running applications used in the provision of telehealth services. Teledentistry services can be provided to Members age 13 and above. Members age 12 and under will require adult supervision and consent in order to receive services through teledentistry.

Predetermination

A predetermination is a request for Us to estimate benefits for a dental treatment You have not yet received. Predetermination is not required for any benefits under the Plan. In estimating benefits, We look at patient eligibility, Dental Necessity and the Plan's coverage for the treatment. Payment of benefits for a predetermined service is subject to Your continued eligibility in the Plan. At the time the claim is paid, We may also correct mathematical errors, apply coordination of benefits, and make adjustments to comply with Your current Plan and applicable Annual Maximums, Lifetime Maximums, or Out-of-Pocket Maximums on the date of service.

Payment of Benefits

If You have treatment performed by a Participating Dentist, We will pay covered benefits directly to the Participating Dentist. Both You and the Dentist will be notified of benefits covered, Our payment and any

Out-of-Pocket Expenses. Payment will be based on the Maximum Allowable Charge Your Participating Dentist has contracted to accept. Maximum Allowable Charges may vary depending on the geographical area of the dental office and the contract between Us and the particular Participating Dentist rendering the service. **Benefits for covered dental emergency services provided by a Non-Participating Dentist will be paid at the same level that would have been paid had the services been rendered by a Participating Dentist.**

If You receive treatment from a Non-Participating Dentist, We will send payment for Covered Services to You unless You the claim indicates that payment should be sent directly to Your treating Dentist. This is called assignment of benefits. You will be notified of the services covered, Our payment and any Out-of-Pocket Expenses. You will be responsible to pay the Dentist any difference between Our payment and the Dentist's full charge for the services. Non-Participating Dentists are not obligated to limit their fees to Our Maximum Allowable Charges.

We are not liable to pay benefits for any services started prior to a Member's Effective Date of coverage. Multi-visit procedures are considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. Procedures started prior to the Member's Effective Date are the liability of the Member.

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

Overpayments

When We make an overpayment for benefits, We have the right to recover the overpayment either from You or from the person or Dentist to whom it was paid. We will recover the overpayment either by requesting a refund or offsetting the amount overpaid from future claim payments. This recovery will follow any applicable state laws or regulations. The Member must provide any assistance necessary, including furnishing information and signing necessary documents, for the Company to be reimbursed.

Coordination of Benefits (COB)

If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, benefits will be coordinated. This means that one plan will be primary and determine its benefits before those of the other plan, and without considering the other plan's benefits. The other plan will be secondary and determine its benefits after the primary plan. The secondary plan's benefits may be reduced because of the primary plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this Plan will determine payment.

1. When used in this Coordination of Benefits section, the following words and phrases have the definitions below:

    A) **Allowable Amount** is the Plan's allowance for items of expense, when the care is covered at least in part by one or more Plans covering the Member for whom the claim is made.
    B) **Claim Determination Period** means a benefit year. However, it does not include any part of a year during which a person has no coverage under this Plan.
    C) **Other Dental Plan** is any form of coverage which is separate from this Plan with which coordination is allowed. **Other Dental Plan** will be any of the following which provides dental benefits, or services, for the following: Group insurance or group type coverage, whether insured or uninsured. It also includes coverage other than school accident type coverage (including grammar, high school and college student coverages) for accidents only, including athletic injury, either on a twenty-four (24) hour basis or on a "to and from school basis," or group or group type hospital indemnity benefits of $100 per day or less.
    D) **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.

E) **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.
F) **Plan** means this document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.

2. The fair value of services provided by the Company will be considered to be the amount of benefits paid by the Company. The Company will be fully discharged from liability to the extent of such payment under this provision.

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

A) If the other plan does not have a provision similar to this one, then that plan will be primary.
B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.
C) Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:
    1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
    2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
    3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
    4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
D) Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:
    1) First, the plan of the parent with custody of the child.
    2) Then, the plan of the Spouse of the parent with the custody of the child; and
    3) Finally, the plan of the parent not having custody of the child.
    4) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
    5) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 3-C) above, titled Dependent Child/Parents Not Separated or Divorced.
E) Active/Inactive Member
    1) For actively employed Members and their Spouses over the age of sixty-five (65) who are covered by Medicare, the plan will be primary.
    2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.
F) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary.
G) The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a Member or a Dependent.

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

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

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

Review of a Benefit Determination

If You are not satisfied with a benefit determination or payment, please contact Our Customer Service Department at the toll-free telephone number in the Introduction section of this Certificate or on Your ID card. If, after speaking with a Customer Service representative, You are still dissatisfied, refer to the Appeal Procedure Addendum attached to this Certificate for further steps You can take regarding Your claim.

Value-Added Programs and Services

From time to time, We offer Members access to various lifestyle, health and/or value-added programs and services. Such offerings are subject to change at any time without notice. Contact Your Group or call Customer Service for eligibility requirements and other information. Eligibility requirements for these programs and services are applied in a uniform, non-discriminatory manner to all Members.

TERMINATION -- WHEN COVERAGE ENDS

A Member's coverage will end:

- when You no longer meet Your Group's eligibility requirements; or
- when Premium payment ceases for You; or
- when you no longer meet the eligibility requirements for a Dependent, as defined in the Definitions section of this Certificate.

On the date the Certificate Holder's coverage ends or the Certificate Holder is no longer eligible to enroll his/her Dependents, Dependent coverage will end unless otherwise specified in any applicable addendum or endorsement to this Certificate. If the Group Policy is cancelled, Certificate Holder and Dependent coverage will end on the Group Policy Termination Date.

If the Policyholder fails to pay Premium, coverage will remain in effect during the Grace Period. If the Premium is not received by the end of the Grace Period, the Group Policy will be cancelled and coverage will terminate on the last date for which Premium was paid.

Benefits After Coverage Terminates

We are not liable to pay any benefits for services, including those predetermined, that are started after Your Termination Date or after the Group Policy Termination Date. However, coverage for completion of a dental procedure requiring two (2) or more visits on separate days will be extended for a period of ninety (90) days after the Termination Date in order for the procedure to be finished. The procedure must be started prior to the Termination Date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Member's Termination Date. This extension does not apply if the Group Policy terminates for failure to pay Premium.

CONTINUATION COVERAGE

Federal or state law may require that certain employers offer continuation coverage to Members for a period of time upon the Certificate Holder's reduction of work hours or termination of employment for any reason other than gross misconduct. Contact Your Group to find out if this applies to You. Your Group will advise You of Your rights to continuation coverage and the cost. If applicable, You must elect to continue coverage within sixty (60) days from Your qualifying event or from notification of rights by Your Group, whichever is later. Dependents may have separate election rights, or You may elect to continue coverage for them. You must pay the required premium for continuation coverage directly to Your Group. The Company is not responsible for determining who is eligible for continuation coverage.

GENERAL PROVISIONS

The failure of any section or subsection of this Certificate shall not affect the validity, legality and enforceability of the remaining sections.

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

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

This Certificate will be construed for all purposes as a legal document and will be interpreted and enforced in accordance with pertinent laws and regulations of Georgia.

Legal Actions

No action at law or inequity shall be brought to recover on this Certificate prior to the expiration of 60 days after a claim has been filed in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of 3 years after the time a claim is required to be filed.

Right of Recovery

If You or Your covered Dependent has a claim for damages or a right to recover damages from a third party or parties for any illness or injury for which benefits are payable under this Plan, the Company may have a right of recovery. Our right of recovery shall be limited to the recovery of any benefits paid for identical Covered Services under this Plan, but shall not include non-dental items. Money received for future dental care or pain and suffering may not be recovered. The Company's right of recovery may include compromised settlements. You or Your attorney must inform the Company of any legal action or settlement agreement at least 10 days prior to settlement or trial. The Company will notify You of the amount it seeks to recover for covered benefits paid. Our recovery may be reduced by the pro-rata share of Your attorney's fees and expenses of litigation.

ADDENDUM TO CERTIFICATE

APPEAL PROCEDURE

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

If You are dissatisfied with Our benefit determination on a claim, You or Your Authorized Representative may appeal Our decision by following the steps outlined in this procedure. We will resolve Your appeal in a thorough, appropriate, and timely manner to ensure that You are afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the Plan documents and consistently among claimants. You or Your Authorized Representative may submit written comments, documents, records and other information relating to claims or appeals. We will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by Us required under these procedures will be supplied to You or Your Authorized Representative.

DEFINITIONS

The following terms when used in this document have the meanings shown below.

"Adverse Benefit Determination" is a denial, reduction, or termination of or failure to make payment (in whole or in part) for a Claim for Benefits based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is Experimental or Investigational, not Dentally Necessary, not Medically Necessary or not appropriate.

"Authorized Representative" is a person granted authority by You and the Company to act on Your behalf regarding a Claim for Benefits or an appeal of an Adverse Benefit Determination. An assignment of benefits is not a grant of authority to act on Your behalf in pursuing and appealing a benefit determination.

"Claim for Benefits" is a request for a plan benefit or benefits by You in accordance with the Plan's reasonable procedure for filing benefit claims, including Pre-service and Post-service Claims.

"Pre-service Claim" is a Claim for Benefits under the Plan when the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

"Post-service Claim" ("Claim") is any Claim for Benefits under a group health plan that is not a Pre-service Claim.

"Relevant" A document, record, or other information will be considered "**relevant**" to a given claim:

a) if it was relied on in making the benefit determination;
b) if it was submitted, considered, or generated in the course of making the benefit determination (even if the Plan did not rely on it);
c) if it demonstrated that, in making the determination, the Plan followed its own administrative processes and safeguards for ensuring appropriate decision-making and consistency;
d) or if it is a statement of the Plan's policy or guidance concerning the denied benefit, without regard to whether it was relied upon in making the benefit determination.

PROCEDURE FOR PRE-SERVICE CLAIM

You or Your Authorized Representative have 180 days from the date You or Your Authorized Representative received notice of the Adverse Benefit Determination to appeal the decision. To file an appeal, call the toll-free telephone number listed in Your Certificate of Coverage or on Your ID card.

The dentist advisor involved in the appeal will be different from and not a subordinate of the dentist advisor involved in the adverse determination on initial Claim for Benefits. We will provide You or Your Authorized Representative with written or electronic notice of Our appeal decision within 30 days of the request to review the Adverse Benefit Determination. The notice of Our appeal decision will include the following:

a) The specific reason for the appeal decision;
b) A reference to specific plan provisions on which the decision was based;
c) A statement that You or Your Authorized Representative is entitled reasonable access to and copies of all relevant documents, records, and criteria. This includes an explanation of clinical judgment on which the decision was based and identification of the dental experts. All such information is available upon request and is free of charge.
d) A statement of Your or Your Authorized Representative's right to bring a civil action under ERISA; and
e) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

PROCEDURE FOR POST-SERVICE CLAIM

You or Your authorized representative may file an appeal with Us within 180 days of receipt of an adverse benefit determination. To file an appeal, telephone the toll-free number listed in Your Certificate of Insurance or on Your ID card.

We will review the claim and notify You of Our decision within 60 days of the request for appeal. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination.

Notice of the appeal decision will include the following in written or electronic form:

a) the specific reason for the appeal decision;
b) reference to specific plan provisions on which the decision was based;
c) a statement that You are entitled to receive reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts; All such information is available upon request and is free of charge.
d) a statement of Your right to bring a civil action under ERISA; and
e) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
f) The option of seeking an independent review through a certified independent review agent if the service is greater than $500.00 33-20A-33.

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 INSURANCE COMPANY

ADDENDUM

TO

GROUP POLICY AND CERTIFICATE OF INSURANCE

This Addendum is effective on the Effective Date as stated in the Group Policy and attached to and made part of the Group Policy and Certificate of Insurance.

The following language is added to the Group Policy and Certificate of Insurance:

> The Company uses Maximum Allowable Charge schedules to determine claim payments. Payment is the lesser of the dentist's submitted charge or the Maximum Allowable Charge.
>
> In-Network Maximum Allowable Charges for Covered Services are determined by geographical area of the dental office or otherwise negotiated. The In-Network Maximum Allowable Charges in the geographical area of the dental office are used to calculate the Company's payment on claims. In-Network Maximum Allowable Charges are reviewed periodically and adjusted as appropriate to reflect increased dentist fees within the geographical areas. Participating Dentists accept their contracted Maximum Allowable Charges as payment in full for Covered Services.
>
> Out-of-Network Maximum Allowable Charges are derived from a targeted percentile of dentist charges for Covered Services by grouping the 90th percentile of dentist charges into different geographical areas. The Out-of-Network Maximum Allowable Charges at the indicated percentile in the geographical area of the dental office are used to calculate the Company's payment on Non-Participating Dentist claims. The source of the dentist charge data is select charge data purchased by the Company supplemented where necessary by internal claim data. Out-of-Network Maximum Allowable Charges are calculated at a set point of time and updated periodically.

United Concordia Insurance Company

Schedule of Benefits

Concordia Flex^{sm}

Group Name: Effingham County Board of Education
Group Number(s): 926682002, 926682003, 926682008, 926682009, 926682199, 926682499
Effective Date: January 1, 2025

The grid below provides information related to Covered Services under this Plan. If a service is a Covered Service, a percentage greater than zero in the column titled "Plan Pays" will be indicated. If a Covered Service has a Waiting Period, the Waiting Period will be listed in the column titled "Waiting Period." Some services will be covered in full prior to the Deductible being met. If this is the case, the "Deductible Application" column will indicate "no." If the Deductible must be met prior to a service being covered at the indicated coinsurance, then "yes" will appear in the "Deductible Application column. Only Covered Services are subject to reimbursement. All services on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations. Consult Your Certificate for more details on the services listed. Riders may affect coverage levels. Participating Dentists accept the Maximum Allowable Charge as payment in full.

Service Category	Waiting Period	Plan Pays	Deductible Application
Diagnostic Services			
Oral Evaluations (Exams)	***None***	***100%***	***No***
Screenings and Patient Assessments	***None***	***100%***	***No***
Pulp Vitality Tests and Bacteriological Studies	***None***	***80%***	***Yes***
Collection and preparation of genetic and saliva sample material for laboratory analysis and report	***None***	***80%***	***Yes***
Diagnostic Casts	***None***	***80%***	***Yes***
Radiographs (X-Rays)			
Bitewings	***None***	***100%***	***No***
Full Mouth	***None***	***80%***	***Yes***
Occlusal Films	***None***	***100%***	***No***
Preventive Services			
Prophylaxis (Cleanings)	***None***	***100%***	***No***
Fluoride	***None***	***100%***	***No***
Sealants and Sealant Repairs	***None***	***80%***	***Yes***
Space Maintainers	***None***	***100%***	***No***
Restorative Services			
Restorations	***None***	***80%***	***Yes***
Single Crowns	***None***	***50%***	***Yes***

Service Category	Waiting Period	Plan Pays	Deductible Application
Single Implant Crowns	***None***	***50%***	***Yes***
Stainless Steel Crowns *	***None***	***80%***	***Yes***
Inlays *	***None***	***50%***	***Yes***
Onlays *	***None***	***50%***	***Yes***
Inlay Repairs	***None***	***80%***	***Yes***
Onlay Repairs	***None***	***80%***	***Yes***
Crown Repair	***None***	***80%***	***Yes***
Pulp Capping (excluding final restoration)	***None***	***50%***	***Yes***
Endodontic Services			
Endodontic Therapy (Root canals, etc.)	***None***	***50%***	***Yes***
Root Canal Retreatment	***None***	***50%***	***Yes***
Apicoectomy/Periradicular (Root Surgery)	***None***	***50%***	***Yes***
Guided Tissue Regeneration	***None***	***50%***	***Yes***
Periodontal Services			
Surgical Periodontics	***None***	***50%***	***Yes***
Non-Surgical Periodontics	***None***	***80%***	***Yes***
Periodontal Maintenance	***None***	***80%***	***Yes***
Local Chemotherapeutic Agents	***None***	***80%***	***Yes***
Prosthodontic Services			
Removable Complete and Partial Dentures	***None***	***50%***	***Yes***
Fixed Partial Dentures (Bridges)	***None***	***50%***	***Yes***
Adjustments of Complete and Partial Dentures	***None***	***80%***	***Yes***
Tissue Conditioning	***None***	***50%***	***Yes***
Removal of Teeth			
Simple Extractions	***None***	***80%***	***Yes***
Surgical Removal	***None***	***50%***	***Yes***
Adjunctive General Services			
Consultations	***None***	***100%***	***No***
General Anesthesia, Nitrous Oxide and/or IV Sedation	***None***	***80%***	***Yes***
Injections of Therapeutic Drugs	***None***	***80%***	***Yes***

Service Category	Waiting Period	Plan Pays	Deductible Application
Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed	***None***	***80%***	***Yes***
Palliative Treatment (Emergency)	***None***	***80%***	***Yes***
Occlusal Adjustments	***None***	***80%***	***Yes***
Orthodontic Services			
Cosmetic Orthodontic Services	***None***	***0%***	***N/A***

Deductibles & Maximums

- *$75 per calendar year Deductible per Member not to exceed $225 per family*
- *$1,250 per calendar year Maximum per Member*

UNITED CONCORDIA INSURANCE COMPANY

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – The following services, supplies or charges are excluded:

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (for example but not limitation, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).
3. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.
4. For prescription and non-prescription drugs, vitamins or dietary supplements.
5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.
6. Which are Cosmetic in nature as determined by the Company (for example but not limitation, bleaching, whitening, personalization of crowns).
7. Elective procedures.
8. Procedures performed when poor prognosis is indicated.
9. Those procedures considered experimental and investigational based on current standards of dental treatment.
10. Those performed for the comfort and convenience of the Member or provider.
11. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).
12. For dental implant services unless specifically covered under the Schedule of Benefits or a Rider.
13. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate in the Schedule of Benefits or a Rider. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
14. For treatment of fractures and dislocations of the jaw.
15. For treatment of malignancies or neoplasms.
16. Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation or reconstruction, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
17. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
18. Periodontal splinting of teeth by any method.
19. For duplicate dentures, prosthetic devices or any other duplicative device.
20. For which in the absence of insurance the Member would incur no charge.
21. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
22. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.
23. For treatment and appliances for bruxism (night grinding of teeth).
24. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.
25. Incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).
26. Procedures that are part of a service but are reported as separate services.
27. Procedures that are reported in a treatment sequence that is not appropriate or categorized as "misreported."
28. Procedures that are misreported or that represent a procedure other than the one reported.
29. Specialized procedures and techniques (for example but not limitation, laser assisted new attachment procedure; laser

assisted peri-implantitis procedure; laser decontamination).

30. Fees for broken appointments.
31. Those specifically listed on the Schedule of Benefits as “Not Covered” or “Plan Pays 0%”.
32. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.
33. Orthodontic services, supplies, and appliances.

LIMITATIONS – Covered services are limited as detailed below. Services are covered until 12:00 a.m. of the birthday when the patient reaches any stated age:

1. Full mouth x-rays – one (1) full mouth x-ray every 60 months.
2. Bitewing x-rays – one (1) set(s) per 1 calendar year(s).
3. Oral Evaluations:
   - Comprehensive and periodic – two (2) of these services per 12 months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
   - Limited problem focused and consultations – (2) of these services per dentist per patient per 12 months.
   - Detailed problem focused – one (1) per dentist per patient per 12 months per eligible diagnosis.
4. Screenings, including state or federally mandated screenings, to determine an individual’s need to be seen by a dentist for diagnosis –once every 6 months.
5. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment) –once every 6 months.
6. Collection and preparation of genetic and/or saliva sample material for laboratory analysis and report – no more than once per lifetime each.
7. Prophylaxis – two (2) per 12 months.
8. Fluoride treatment – two (2) per 12 months under age nineteen (19).
9. Space maintainers – one (1) per three (3) year period for Members under age sixteen (16) when used to maintain space as a result of prematurely lost teeth that have not, or will not, develop.
10. Sealants or sealant repairs – one (1) per tooth per 60 months under age sixteen (16) on permanent first and second molars.
11. Prefabricated crowns – one (1) per tooth per lifetime for Members under age fifteen (15).
12. Periodontal Services:
    - Full mouth debridement – one (1) per lifetime.
    - Periodontal maintenance following active periodontal therapy – two (2) per 1 calendar year(s).
    - Periodontal scaling and root planing – one (1) per 24 months per area of the mouth.
    - Surgical periodontal procedures – one (1) per 24 months per area of the mouth.
    - Guided tissue regeneration – one (1) per tooth per lifetime.
13. Restorative services:
    - Labial veneers – once per tooth per 10 year(s).
14. Replacement of restorative services only when they are not, and cannot be made, serviceable:
    - Basic restorations – not within 12 months of previous placement of any basic restoration unless a new surface of decay is identified on the tooth.
    - Single crowns, inlays, onlays – not within 10 year(s) of previous placement of any of the procedures in this category.
    - Buildups and post and cores – not within 10 year(s) of previous placement of any of the procedures in this category.
    - Replacement of natural tooth/teeth in an arch – not within 10 year(s) of a fixed partial denture, full denture or partial removable denture.
    - Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.

15. Tissue conditioning – once in a 36-month period.
16. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every 24 months thereafter.
17. Pulpal therapy – one (1) per primary tooth per lifetime only when there is no permanent tooth to replace it.
18. Root canal retreatment – one (1) per tooth per lifetime.
19. Recementation – one (1) per 12 months. Recementation during the first 12 months following insertion any preventive, restorative or prosthodontic service by the same dentist is included in the preventive, restorative or prosthodontic service benefit.
20. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.
21. Intraoral films:
    - Periapical – four (4) per 12 months per dentist if not performed in conjunction with definitive procedure(s).
    - Occlusal – one (1) per 12 months under age eight (8).
22. General anesthesia and IV sedation: a total of 60 minutes per session.
23. Occlusal adjustments – once every 12 months.

United Concordia

Rider to Schedule of Benefits and Schedule of Exclusions and Limitations

Implantology Rider

This Rider is effective on the date issued to the Policyholder and is attached to and made a part of the Certificate of Insurance.

Except where specifically changed by this Rider, all of the terms and conditions of Your Plan's Certificate of Insurance, Schedule of Benefits and Schedule of Exclusions and Limitations also apply to this Rider. In the event of a conflict between the provisions in this Rider and the Certificate of Insurance, Schedule of Benefits or Schedule of Exclusions and Limitations, this Rider shall control.

SCHEDULE OF BENEFITS

The Company will pay implantology benefits for eligible Members for the following Covered Services equal to 50% of the Maximum Allowable Charge.

Implantology Services

Implant Placement

- Endosteal
- Eposteal
- Transosteal
- Mini

Surgical Services

- Second stage implant surgery
- Implant removal
- Debridement of periimplant defects
- Debridement and osseous contouring of periimplant defect
- Bone graft at time of implant placement

Supporting Structures

- Connecting bar
- Prefabricated abutment
- Custom fabricated abutment

Implant/Abutment Supported Prosthetics

- Removable Dentures
- Fixed Dentures (Hybrid Prosthesis)
- Single Crowns
- Fixed Partial Dentures

Other Implant Related Procedures

- Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla
- Sinus augmentation, lateral open approach
- Sinus augmentation, vertical approach
- Bone replacement graft for ridge preservation

Deductible(s)

The annual Deductibles indicated on the Schedule of Benefits will be applied to implantology services.

Maximum(s)

The annual Maximum indicated on the Schedule of Benefits will be applied to implantology services.

Waiting Period(s)

No Waiting Period will be applied to implantology services.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

The Schedule of Exclusions and Limitations is amended as follows:

Exclusions

Any exclusions relating to implantology services are deleted.

Limitations

The following limitation does not apply to the above listed implantology procedures:

> An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist.

The following limitations are added to the Schedule of Exclusions and Limitations:

> All implantology services are limited to Member's age eighteen (18) and older.
>
> All implantology services (not inclusive of prosthetics) are limited to one (1) per tooth per lifetime.
>
> Implant prosthetics limited to one (1) per ten (10) years.
>
> Mini implants limited to one (1) per tooth per lifetime and a maximum of four (4) per arch per lifetime, in support of a complete removable denture.

Officer's Signature

UNITED CONCORDIA INSURANCE COMPANY

Tuition Reward Program Endorsement

This Endorsement is effective on the Policy Effective Date to the Policyholder and is attached to and made a part of the Group Policy. Capitalized terms not otherwise defined in this Endorsement are defined in the Certificate of Insurance.

As a Certificate Holder enrolled in this United Concordia Group Policy, You are eligible for the College Tuition Reward Program (the "Program"). The Program is not a United Concordia Insurance Company ("United Concordia") product. It is offered to United Concordia Certificate Holders through an arrangement with SAGE CTB LLC ("SAGE"). SAGE, not United Concordia, is solely responsible for the Program, including maintaining the network of participating private colleges and universities, determining reward credits, record keeping, and administration of this Program. United Concordia assumes no liability for the services provided under this Program.

How to Earn College Tuition Rewards
The Program allows each Certificate Holder to accumulate points ("Tuition Rewards") that can be applied toward the full tuition cost for students attending colleges and universities that participate in the SAGE Scholars, Inc. network. Subject to Sage's terms and conditions, each earned Tuition Reward is equivalent to one dollar ($1.00) of tuition reduction that may be used to offset the full tuition bill at participating colleges and universities. Tuition Reward Account balances have no cash value and terms and conditions apply to their use.

Tuition Rewards are accumulated and distributed to eligible students according to SAGE terms and conditions. Please refer to the current SAGE terms and conditions for complete details or contact SAGE's customer service for additional information.

Important dates and time frames related to the use of accumulated Tuition Rewards include the following.

- When the Certificate Holder has a registered 11th grade student, SAGE will email the Certificate Holder instructions for activating the Tuition Rewards account for that student.
- The Certificate Holder must complete SAGE's online activation process before August 24th of the student's 12th grade year.
- Within ten (10) days of applying to a participating college, the Certificate Holder or student must submit a Tuition Rewards statement to the participating college.

Refer to the program instructions provided by SAGE for further details related to Tuition Rewards.

Participating Colleges and Universities:
SAGE maintains a network of participating colleges and universities that accept its Tuition Rewards. All participating institutions are accredited, four-year, not-for-profit, colleges and universities. The list of participating institutions is maintained at the following website:
https://secure.tuitionrewards.com/index.cfm?p=colleges.
SAGE cannot guarantee the continued participation of any specific college in the future.

Tuition Rewards Program Information and Questions:
For additional information related to the SAGE Tuition Rewards Program or the SAGE Scholars, Inc. college network, contact SAGE directly by telephone at (844) 244-4086 or in writing at the address below:

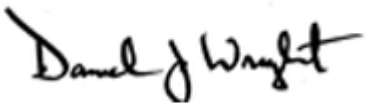
434 Devon Park Drive
Building 400, Suite 410
Wayne, PA 19087
www.collegetuitionbenefit.com

All disputes with regard to the Tuition Rewards program will be settled in accordance with SAGE's terms and conditions and program rules.

Termination:
Certificate Holders registered with SAGE retain the rights to their earned Tuition Rewards after their coverage under this United Concordia Group Policy ends. In the event United Concordia and SAGE discontinue this offering for any reason, Tuition Rewards earned prior to the date the program is discontinued will continue in force and may be used by the Certificate Holder's eligible students in accordance with SAGE's terms and conditions.

Certificate Holders may terminate participation in the College Tuition Rewards Program at any time by providing notice of intent to terminate to SAGE. Termination of participation status with SAGE does not affect eligibility for Covered Services under this Group Policy. To terminate participation in the College Tuition Rewards Program, send a notice by email to support@sagescholars.com or by regular mail to SAGE Scholars Inc., 1600 Arch Street, Suite 2502, Philadelphia, PA 19103.

General:
The terms and conditions related to the College Tuition Reward Program described by this Endorsement do not change the dental Plan's Group Policy and Certificate of Insurance, to which this Endorsement is attached. In the event of a conflict between the provisions in this Endorsement and the Certificate of Insurance or Group Policy, the Certificate of Insurance or Group Policy will control. Some states and/or jurisdictions may not permit use of this program for individuals under their jurisdiction.



Officer Signature

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

The Plan:

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

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

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

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

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

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

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-332-0366 (TTY: 711).
Español (Spanish)	ATENCIÓN: Si habla español, le ofrecemos servicios gratuitos de asistencia lingüística. Llame al 1-800-332-0366 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-0366 (TTY: 711)。
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-800-332-0366 (TTY: 711).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-0366 (TTY: 711) 번으로 전화해 주십시오.
Tagalog (Tagalog - Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-332-0366 (TTY: 711).
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните 1-800-332-0366 (телетайп: 711).
العربية (Arabic)	يرجى الانتباه: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة للغوية المجانية. اتصل على 1-800-332-0366 (TTY: 711)
Kreyòl Ayisyen (French Creole)	ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis èd nan lang ki disponib gratis pou ou. Rele nimewo 1-800-332-0366 (TTY: 711).
Français (French)	ATTENTION : si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Appelez le 1-800-332-0366 (ATS: 711).
Polski (Polish)	UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-0366 (TTY: 711).
Português (Portuguese)	ATENÇÃO: se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-800-332-0366 (TTY: 711).
Italiano (Italian)	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-332-0366 (TTY: 711).
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Dienste für die sprachliche Unterstützung zur Verfügung. Rufnummer: 1-800-332-0366 (TTY: 711).
日本語 (Japanese)	注意事項：日本語をお使いの方は、言語面でのサポートを無償でご利用いただけます。1-800-332-0366（TTY: 711）まで、お電話にてご連絡ください。
فارسی (Farsi)	توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید. 1-800-332-0366 (TTY: 711)

United Concordia dental℠

UNITED CONCORDIA INSURANCE COMPANY

1800 Center Street, Suite 2B 220
Camp Hill, PA 17011

Dental Plan
Certificate of Insurance

EFFINGHAM COUNTY BOARD OF EDUCATION
926682004, 926682005, 926682010, 926682011, 926682299, 926682599
January 1, 2025

United Concordia Dental policies are underwritten by
United Concordia Insurance Company

CERTFICATE OF INSURANCE

INTRODUCTION

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

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

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

800-332-0366

For general information, Participating Dentist or benefit information, You may also log on to our website at:

www.unitedconcordia.com

Claim forms should be sent to:

United Concordia Companies, Inc.
Dental Claims
PO Box 69421
Harrisburg, PA 17106-9421

TABLE OF CONTENTS

DEFINITIONS 4
ELIGIBILITY AND ENROLLMENT 6
HOW THE DENTAL PLAN WORKS 8
BENEFITS 9
TERMINATION 12
CONTINUATION OF COVERAGE 13
GENERAL PROVISIONS 13

Attached:

Appeal Procedure Addendum
Schedule of Benefits
Schedule of Exclusions and Limitations

DEFINITIONS

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

Annual Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during a calendar year or Contract Year as shown on the Schedule of Benefits. When a Member reaches the Annual Maximum, the Company will make no additional payment(s) for Covered Services.

Certificate Holder(s) - An individual who, because of his/her status with the Policyholder, has enrolled him/herself and/or his/her eligible Dependents for dental coverage and for whom Premiums are paid.

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

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

Company - United Concordia, the insurer.

Contract Year- The period of twelve (12) months beginning on the Group Policy's Effective Date or the anniversary of the Group Policy's Effective Date and ending on the day before the Renewal Date.

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

Cosmetic - Services or procedures that are not Dentally Necessary and are primarily intended to improve or otherwise modify the Member's appearance.

Covered Service(s) - Services or procedures shown on the Schedule of Benefits for which benefits will be covered subject to the Schedule of Exclusions and Limitations, when rendered by a Dentist.

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

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

Dentist(s) – A person licensed to practice dentistry in the state in which dental services are provided. Dentist will include any other duly licensed dental professional practicing under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

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

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

1. The Certificate Holder's Spouse and
2. Any natural child, stepchild, adopted child or child placed with the Certificate Holder or the Certificate Holder's Spouse by order of a court or administrative agency:
   (a) until the end of the month that the child reaches age twenty-six (26); or

(b) until the end of the month that the child reaches age twenty-six (26) if he/she is a full-time student at an accredited educational institution and is chiefly reliant upon the Certificate Holder for maintenance and support; or
(c) to any age if the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

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

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

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

Family Policy – A Group Policy that covers the Policyholder's Certificate Holders and may also cover eligible Dependents, as defined in this Certificate. A Group Policy that covers only Certificate Holders is not a Family Policy.

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

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

Lifetime Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during the entire time the Member is enrolled under the Group Policy, as shown on the Schedule of Benefits.

Limitation(s) - The maximum frequency or age limit applied to a Covered Service set forth in the Schedule of Exclusions and Limitations.

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 Us and the particular Participating Dentist rendering the service. Depending upon the Plan purchased by the Policyholder, Maximum Allowable Charges for Covered Services rendered by Non-Participating Dentists may be the same or higher than such charges for Covered Services rendered by Participating Dentists in order to help limit Out-of-Pocket Expenses of Members choosing Non-Participating Dentists.

Member(s) – Enrolled Certificate Holder(s) and their enrolled Dependent(s). Also referred to as "You" or "Your" or "Yourself".

Non-Participating Dentist - A Dentist who has not signed a contract with Us to accept the Company's Maximum Allowable Charges as payment in full for Covered Services.

Out-of-Pocket Expense(s) – Costs not paid by Us, including but not limited to Coinsurance, Deductibles, amounts billed by Non-Participating Dentists that are over the Maximum Allowable Charge, costs of services that exceed the Policy's Limitations or Maximums, or for services that are Exclusions. The Certificate Holder is responsible to pay for Out-of-Pocket Expenses.

Participating Dentist - A Dentist who has executed a Participating Dentist Agreement with Us, under which he/she agrees to accept the Company's Maximum Allowable Charges as payment in full for Covered Services. Participating Dentists may also agree to limit their charges for any other services delivered to Members.

Plan - Dental benefits pursuant to this Certificate and attached Schedule of Exclusions and Limitations and Schedule of Benefits.

Policyholder - Organization that executes the Group Policy. Also referred to as "Your Group".

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

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

Schedule of Benefits - Attached summary of Covered Services, Coinsurances, Deductibles, Waiting Periods and maximums applicable to benefits payable under the Plan.

Schedule of Exclusions and Limitations – Attached list of Exclusions and Limitations applicable to benefits, services, supplies or charges under the Plan.

Special Enrollment Period – The period of time outside Your Group's open enrollment period during which eligible individuals who experience certain qualifying events may enroll as Certificate Holders or Dependents in this Group Policy.

Spouse – The Certificate Holder's partner by marriage or by any union between two adults that is recognized by law in the state where this Group Policy is issued.

Teledentistry/Telehealth dental service – A health care service performed by a dentist, or appropriately licensed health care provider acting under the delegation and supervision of a dentist, to a patient who is at a physical location different than the provider using telecommunications or information technology.

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

Waiting Period(s) - A period of time a Member must be enrolled under the Group Policy before benefits will be paid for certain Covered Services as shown on the attached Schedule of Benefits.

We, Our or Us - The Company, its affiliate or an organization with which it contracts for a provider network and/or to perform certain functions to administer this Policy.

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

In order to be a Member, You must meet the eligibility requirements of Your Group and this Group Policy. We must receive enrollment information for the Certificate Holder, enrolled Dependents, and Policyholder. Provided that We receive applicable Premium, coverage will begin on the date specified in the enrollment information We receive. Your Group will inform Certificate Holders of its eligibility requirements.

If You have already satisfied all eligibility requirements on the Group Policy Effective Date and Your enrollment information and applicable Premium are supplied to Us, Your coverage will begin on the Group Policy Effective Date.

If You are not eligible to be a Member on the Group Policy Effective Date, You must supply the required enrollment information on Yourself and any eligible Dependents, as specified in the Definitions section, within thirty-one (31) days of the date You meet all applicable eligibility requirements.

Coverage for Members enrolling after the Group Policy Effective Date 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 teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. Procedures started prior to the Member's Effective Date are the liability of the Member or a prior insurance carrier.

Special Enrollment Periods - Enrollment Changes

After Your Effective Date, You can change Your enrollment during Your Group's open enrollment period. There are also Special Enrollment Periods when the Certificate Holder may add or remove Dependents. These Special Enrollment Period life change events include:

- birth of a child;
- adoption of a child;
- court order of placement or custody of a child;
- change in student status for a child;
- loss of other coverage; or,
- marriage or other lawful union between two adults.

If You enrolled through Your Group, to enroll a new Dependent as a result of one of these events, You must supply the required enrollment change information within the Special Enrollment Period that is thirty-one (31) days from the date of the life change event. The Dependent must meet the definition of Dependent applicable to this Group Policy.

Except for newly born or adoptive children, coverage for the new Dependent will begin on the date specified in the enrollment information provided to as long as the Premium is paid.

Newly born children of a Member will be considered enrolled from the moment of birth. Adoptive children will be considered enrolled from the date of adoption or placement, except for those adopted or placed within thirty-one (31) days of birth who will be considered enrolled Dependents from the moment of birth. In order for coverage of newly born or adoptive children to continue beyond the first thirty-one (31) day period, the child's enrollment information must be provided to Us and the required Premium must be paid within the first thirty-one (31) day period in which coverage is effective.

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 ninety (90) days after the child 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 thirty (30) days after the child 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 thirty (30) days after the Dependent attains the limiting age for students. Such evidence will be requested thereafter based on information provided by the Member's physician, but no more frequently than annually.

Dependent coverage may only be terminated when certain life change events occur including death, divorce or dissolution of the union or domestic partnership, reaching the limiting age or during open enrollment periods or when otherwise permitted by any applicable law or regulation.

Late Enrollment

If You or Your Dependents are not enrolled within thirty-one (31) days of initial eligibility or during the Special Enrollment Period specified for a life change event, You or Your Dependents cannot enroll until the next Special Enrollment Period or open enrollment period conducted for Your Group. If You are required by court order to provide coverage for a Dependent child, You will be permitted to enroll the Dependent child without regard to enrollment season restrictions.

HOW THE DENTAL PLAN WORKS

Choice of Provider

You may choose any licensed Dentist for services. However, Your Out-of-Pocket Expenses will vary depending upon whether or not Your Dentist is in Our network. If You choose a Participating Dentist, You may limit Your Out-of-Pocket Expense. Participating Dentists agree by contract to accept Maximum Allowable Charges as payment in full for Covered Services. Also, if agreed by the provider, Participating Dentists limit their charges for all services delivered to Members, even if the service is not covered for any reason and a benefit is not paid under this Plan. Participating Dentists also complete and send claims directly to Us for processing. To find a Participating Dentist, visit Our website at www.unitedconcordia.com or call Us at the toll-free number in the Introduction section of this Certificate or on Your ID card.

If You use a Non-Participating Dentist, You may have to pay the Dentist at the time of service, complete and submit Your own claims and wait for Us to reimburse You. You will be responsible for the Dentist's full charge which may exceed Our Maximum Allowable Charge and result in higher Out-of-Pocket Expenses.

Notice of Claims

Written notice of claim must be given to the Company within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Member to the Company, or to any authorized agent of the Company, with information sufficient to identify the Member, shall be deemed notice to the Company.

Claim Forms

The Company, upon receipt of a notice of claim, will furnish to the Member such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 10 days after the Company received notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

The Company will provide claim forms to and accept claims for filing proof of loss submitted by a custodial parent of an eligible Dependent child who is the subject of a court or administrative order relating to provision of health care coverage. If services are provided by a Non-Participating Dentist, the Company will make payments directly to such custodial parent or to the Department of Public Welfare if benefits are payable under Medical Assistance.

Proof of Loss

Written proof of loss must be furnished to the Company at its said office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 30 days after the termination of the period for which the Company is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

The acknowledgment by the Company of the receipt of notice given or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the Company in defense of any claim arising under such policy.

Time Payment of Claims

All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid no later than 30 days and acknowledge no later than 15 days from receipt of due written proof of such loss. The Company may extend this 30-day period by no more than 15 days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Company. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid quarterly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. Benefits not paid in accordance with this provision, Company shall pay 18 percent per annum on the proceeds overdue under the Plan for benefits not paid in accordance with this provision.

Physical Examinations

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

BENEFITS

Covered Services

Benefits and any applicable Coinsurance, Deductibles, Annual Maximums, Lifetime Maximums, Out-of-Pocket Maximums and Waiting Periods are shown on the attached Schedule of Benefits. Covered Services shown on the Schedule of Benefits must be Dentally Necessary unless otherwise specified in a Rider to this Group Policy and are subject to frequency or age Limitations detailed on the attached Schedule of Exclusions and Limitations.

No benefits will be paid for services, supplies or charges detailed under the Exclusions on the Schedule of Exclusions and Limitations, and no benefits will be paid for services on the Schedule of Benefits with a Coinsurance of zero (0).

TeleDentistry

Covered Services provided through Teledentistry are reimbursed on the same basis and to the same extent as coverage for the services provided in an in-person setting. Coverage is without regard to whether the service is provided in an in-person setting or virtually (i.e. through teledentistry). Covered Services provided through teledentistry accumulate to Your Annual Maximum, Deductible and frequency limitations, as applicable.

In order to receive Covered Services in a virtual setting, You will need an internet-ready device capable of running applications used in the provision of telehealth services. Teledentistry services can be provided to Members age 13 and above. Members age 12 and under will require adult supervision and consent in order to receive services through teledentistry.

Predetermination

A predetermination is a request for Us to estimate benefits for a dental treatment You have not yet received. Predetermination is not required for any benefits under the Plan. In estimating benefits, We look at patient eligibility, Dental Necessity and the Plan's coverage for the treatment. Payment of benefits for a predetermined service is subject to Your continued eligibility in the Plan. At the time the claim is paid, We may also correct mathematical errors, apply coordination of benefits, and make adjustments to comply with Your current Plan and applicable Annual Maximums, Lifetime Maximums, or Out-of-Pocket Maximums on the date of service.

Payment of Benefits

If You have treatment performed by a Participating Dentist, We will pay covered benefits directly to the Participating Dentist. Both You and the Dentist will be notified of benefits covered, Our payment and any

Out-of-Pocket Expenses. Payment will be based on the Maximum Allowable Charge Your Participating Dentist has contracted to accept. Maximum Allowable Charges may vary depending on the geographical area of the dental office and the contract between Us and the particular Participating Dentist rendering the service. **Benefits for covered dental emergency services provided by a Non-Participating Dentist will be paid at the same level that would have been paid had the services been rendered by a Participating Dentist.**

If You receive treatment from a Non-Participating Dentist, We will send payment for Covered Services to You unless You the claim indicates that payment should be sent directly to Your treating Dentist. This is called assignment of benefits. You will be notified of the services covered, Our payment and any Out-of-Pocket Expenses. You will be responsible to pay the Dentist any difference between Our payment and the Dentist's full charge for the services. Non-Participating Dentists are not obligated to limit their fees to Our Maximum Allowable Charges.

We are not liable to pay benefits for any services started prior to a Member's Effective Date of coverage. Multi-visit procedures are considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. Procedures started prior to the Member's Effective Date are the liability of the Member.

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

Overpayments

When We make an overpayment for benefits, We have the right to recover the overpayment either from You or from the person or Dentist to whom it was paid. We will recover the overpayment either by requesting a refund or offsetting the amount overpaid from future claim payments. This recovery will follow any applicable state laws or regulations. The Member must provide any assistance necessary, including furnishing information and signing necessary documents, for the Company to be reimbursed.

Coordination of Benefits (COB)

If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, benefits will be coordinated. This means that one plan will be primary and determine its benefits before those of the other plan, and without considering the other plan's benefits. The other plan will be secondary and determine its benefits after the primary plan. The secondary plan's benefits may be reduced because of the primary plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this Plan will determine payment.

1. When used in this Coordination of Benefits section, the following words and phrases have the definitions below:

    A) **Allowable Amount** is the Plan's allowance for items of expense, when the care is covered at least in part by one or more Plans covering the Member for whom the claim is made.
    B) **Claim Determination Period** means a benefit year. However, it does not include any part of a year during which a person has no coverage under this Plan.
    C) **Other Dental Plan** is any form of coverage which is separate from this Plan with which coordination is allowed. **Other Dental Plan** will be any of the following which provides dental benefits, or services, for the following: Group insurance or group type coverage, whether insured or uninsured. It also includes coverage other than school accident type coverage (including grammar, high school and college student coverages) for accidents only, including athletic injury, either on a twenty-four (24) hour basis or on a "to and from school basis," or group or group type hospital indemnity benefits of $100 per day or less.
    D) **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.

E) **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.
F) **Plan** means this document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.

2. The fair value of services provided by the Company will be considered to be the amount of benefits paid by the Company. The Company will be fully discharged from liability to the extent of such payment under this provision.

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

A) If the other plan does not have a provision similar to this one, then that plan will be primary.
B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.
C) Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:
    1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
    2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
    3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
    4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
D) Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:
    1) First, the plan of the parent with custody of the child.
    2) Then, the plan of the Spouse of the parent with the custody of the child; and
    3) Finally, the plan of the parent not having custody of the child.
    4) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
    5) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 3-C) above, titled Dependent Child/Parents Not Separated or Divorced.
E) Active/Inactive Member
    1) For actively employed Members and their Spouses over the age of sixty-five (65) who are covered by Medicare, the plan will be primary.
    2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.
F) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary.
G) The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a Member or a Dependent.

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

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

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

Review of a Benefit Determination

If You are not satisfied with a benefit determination or payment, please contact Our Customer Service Department at the toll-free telephone number in the Introduction section of this Certificate or on Your ID card. If, after speaking with a Customer Service representative, You are still dissatisfied, refer to the Appeal Procedure Addendum attached to this Certificate for further steps You can take regarding Your claim.

Value-Added Programs and Services

From time to time, We offer Members access to various lifestyle, health and/or value-added programs and services. Such offerings are subject to change at any time without notice. Contact Your Group or call Customer Service for eligibility requirements and other information. Eligibility requirements for these programs and services are applied in a uniform, non-discriminatory manner to all Members.

TERMINATION -- WHEN COVERAGE ENDS

A Member's coverage will end:

- when You no longer meet Your Group's eligibility requirements; or
- when Premium payment ceases for You; or
- when you no longer meet the eligibility requirements for a Dependent, as defined in the Definitions section of this Certificate.

On the date the Certificate Holder's coverage ends or the Certificate Holder is no longer eligible to enroll his/her Dependents, Dependent coverage will end unless otherwise specified in any applicable addendum or endorsement to this Certificate. If the Group Policy is cancelled, Certificate Holder and Dependent coverage will end on the Group Policy Termination Date.

If the Policyholder fails to pay Premium, coverage will remain in effect during the Grace Period. If the Premium is not received by the end of the Grace Period, the Group Policy will be cancelled and coverage will terminate on the last date for which Premium was paid.

Benefits After Coverage Terminates

We are not liable to pay any benefits for services, including those predetermined, that are started after Your Termination Date or after the Group Policy Termination Date. However, coverage for completion of a dental procedure requiring two (2) or more visits on separate days will be extended for a period of ninety (90) days after the Termination Date in order for the procedure to be finished. The procedure must be started prior to the Termination Date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Member's Termination Date. This extension does not apply if the Group Policy terminates for failure to pay Premium.

CONTINUATION COVERAGE

Federal or state law may require that certain employers offer continuation coverage to Members for a period of time upon the Certificate Holder's reduction of work hours or termination of employment for any reason other than gross misconduct. Contact Your Group to find out if this applies to You. Your Group will advise You of Your rights to continuation coverage and the cost. If applicable, You must elect to continue coverage within sixty (60) days from Your qualifying event or from notification of rights by Your Group, whichever is later. Dependents may have separate election rights, or You may elect to continue coverage for them. You must pay the required premium for continuation coverage directly to Your Group. The Company is not responsible for determining who is eligible for continuation coverage.

GENERAL PROVISIONS

The failure of any section or subsection of this Certificate shall not affect the validity, legality and enforceability of the remaining sections.

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

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

This Certificate will be construed for all purposes as a legal document and will be interpreted and enforced in accordance with pertinent laws and regulations of Georgia.

Legal Actions

No action at law or inequity shall be brought to recover on this Certificate prior to the expiration of 60 days after a claim has been filed in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of 3 years after the time a claim is required to be filed.

Right of Recovery

If You or Your covered Dependent has a claim for damages or a right to recover damages from a third party or parties for any illness or injury for which benefits are payable under this Plan, the Company may have a right of recovery. Our right of recovery shall be limited to the recovery of any benefits paid for identical Covered Services under this Plan, but shall not include non-dental items. Money received for future dental care or pain and suffering may not be recovered. The Company's right of recovery may include compromised settlements. You or Your attorney must inform the Company of any legal action or settlement agreement at least 10 days prior to settlement or trial. The Company will notify You of the amount it seeks to recover for covered benefits paid. Our recovery may be reduced by the pro-rata share of Your attorney's fees and expenses of litigation.

ADDENDUM TO CERTIFICATE

APPEAL PROCEDURE

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

If You are dissatisfied with Our benefit determination on a claim, You or Your Authorized Representative may appeal Our decision by following the steps outlined in this procedure. We will resolve Your appeal in a thorough, appropriate, and timely manner to ensure that You are afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the Plan documents and consistently among claimants. You or Your Authorized Representative may submit written comments, documents, records and other information relating to claims or appeals. We will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by Us required under these procedures will be supplied to You or Your Authorized Representative.

DEFINITIONS

The following terms when used in this document have the meanings shown below.

"Adverse Benefit Determination" is a denial, reduction, or termination of or failure to make payment (in whole or in part) for a Claim for Benefits based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is Experimental or Investigational, not Dentally Necessary, not Medically Necessary or not appropriate.

"Authorized Representative" is a person granted authority by You and the Company to act on Your behalf regarding a Claim for Benefits or an appeal of an Adverse Benefit Determination. An assignment of benefits is not a grant of authority to act on Your behalf in pursuing and appealing a benefit determination.

"Claim for Benefits" is a request for a plan benefit or benefits by You in accordance with the Plan's reasonable procedure for filing benefit claims, including Pre-service and Post-service Claims.

"Pre-service Claim" is a Claim for Benefits under the Plan when the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

"Post-service Claim" ("Claim") is any Claim for Benefits under a group health plan that is not a Pre-service Claim.

"Relevant" A document, record, or other information will be considered "**relevant**" to a given claim:

a) if it was relied on in making the benefit determination;
b) if it was submitted, considered, or generated in the course of making the benefit determination (even if the Plan did not rely on it);
c) if it demonstrated that, in making the determination, the Plan followed its own administrative processes and safeguards for ensuring appropriate decision-making and consistency;
d) or if it is a statement of the Plan's policy or guidance concerning the denied benefit, without regard to whether it was relied upon in making the benefit determination.

PROCEDURE FOR PRE-SERVICE CLAIM

You or Your Authorized Representative have 180 days from the date You or Your Authorized Representative received notice of the Adverse Benefit Determination to appeal the decision. To file an appeal, call the toll-free telephone number listed in Your Certificate of Coverage or on Your ID card.

The dentist advisor involved in the appeal will be different from and not a subordinate of the dentist advisor involved in the adverse determination on initial Claim for Benefits. We will provide You or Your Authorized Representative with written or electronic notice of Our appeal decision within 30 days of the request to review the Adverse Benefit Determination. The notice of Our appeal decision will include the following:

a) The specific reason for the appeal decision;
b) A reference to specific plan provisions on which the decision was based;
c) A statement that You or Your Authorized Representative is entitled reasonable access to and copies of all relevant documents, records, and criteria. This includes an explanation of clinical judgment on which the decision was based and identification of the dental experts. All such information is available upon request and is free of charge.
d) A statement of Your or Your Authorized Representative's right to bring a civil action under ERISA; and
e) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

PROCEDURE FOR POST-SERVICE CLAIM

You or Your authorized representative may file an appeal with Us within 180 days of receipt of an adverse benefit determination. To file an appeal, telephone the toll-free number listed in Your Certificate of Insurance or on Your ID card.

We will review the claim and notify You of Our decision within 60 days of the request for appeal. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination.

Notice of the appeal decision will include the following in written or electronic form:

a) the specific reason for the appeal decision;
b) reference to specific plan provisions on which the decision was based;
c) a statement that You are entitled to receive reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts; All such information is available upon request and is free of charge.
d) a statement of Your right to bring a civil action under ERISA; and
e) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
f) The option of seeking an independent review through a certified independent review agent if the service is greater than $500.00 33-20A-33.

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 INSURANCE COMPANY

ADDENDUM

TO

GROUP POLICY AND CERTIFICATE OF INSURANCE

This Addendum is effective on the Effective Date as stated in the Group Policy and attached to and made part of the Group Policy and Certificate of Insurance.

The following language is added to the Group Policy and Certificate of Insurance:

> The Company uses Maximum Allowable Charge schedules to determine claim payments. Payment is the lesser of the dentist's submitted charge or the Maximum Allowable Charge.
>
> In-Network Maximum Allowable Charges for Covered Services are determined by geographical area of the dental office or otherwise negotiated. The In-Network Maximum Allowable Charges in the geographical area of the dental office are used to calculate the Company's payment on claims. In-Network Maximum Allowable Charges are reviewed periodically and adjusted as appropriate to reflect increased dentist fees within the geographical areas. Participating Dentists accept their contracted Maximum Allowable Charges as payment in full for Covered Services.
>
> Out-of-Network Maximum Allowable Charges are derived from a targeted percentile of dentist charges for Covered Services by grouping the 90th percentile of dentist charges into different geographical areas. The Out-of-Network Maximum Allowable Charges at the indicated percentile in the geographical area of the dental office are used to calculate the Company's payment on Non-Participating Dentist claims. The source of the dentist charge data is select charge data purchased by the Company supplemented where necessary by internal claim data. Out-of-Network Maximum Allowable Charges are calculated at a set point of time and updated periodically.

United Concordia Insurance Company

Schedule of Benefits

Concordia Flex[sm]

Group Name: Effingham County Board of Education
Group Number(s): 926682004, 926682005, 926682010, 926682011, 926682299, 926682599
Effective Date: January 1, 2025

The grid below provides information related to Covered Services under this Plan. If a service is a Covered Service, a percentage greater than zero in the column titled "Plan Pays" will be indicated. If a Covered Service has a Waiting Period, the Waiting Period will be listed in the column titled "Waiting Period." Some services will be covered in full prior to the Deductible being met. If this is the case, the "Deductible Application" column will indicate "no." If the Deductible must be met prior to a service being covered at the indicated coinsurance, then "yes" will appear in the "Deductible Application column. Only Covered Services are subject to reimbursement. All services on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations. Consult Your Certificate for more details on the services listed. Riders may affect coverage levels. Participating Dentists accept the Maximum Allowable Charge as payment in full.

Service Category	Waiting Period	Plan Pays	Deductible Application
Diagnostic Services			
Oral Evaluations (Exams)	***None***	***100%***	***No***
Screenings and Patient Assessments	***None***	***100%***	***No***
Pulp Vitality Tests and Bacteriological Studies	***None***	***80%***	***Yes***
Collection and preparation of genetic and saliva sample material for laboratory analysis and report	***None***	***80%***	***Yes***
Diagnostic Casts	***None***	***80%***	***Yes***
Radiographs (X-Rays)			
Bitewings	***None***	***100%***	***No***
Full Mouth	***None***	***80%***	***Yes***
Occlusal Films	***None***	***100%***	***No***
Preventive Services			
Prophylaxis (Cleanings)	***None***	***100%***	***No***
Fluoride	***None***	***100%***	***No***
Sealants and Sealant Repairs	***None***	***80%***	***Yes***
Space Maintainers	***None***	***100%***	***No***
Restorative Services			
Restorations	***None***	***80%***	***Yes***
Single Crowns	***None***	***50%***	***Yes***

Service Category	Waiting Period	Plan Pays	Deductible Application
Single Implant Crowns	***None***	***50%***	***Yes***
Stainless Steel Crowns *	***None***	***80%***	***Yes***
Inlays *	***None***	***50%***	***Yes***
Onlays *	***None***	***50%***	***Yes***
Inlay Repairs	***None***	***80%***	***Yes***
Onlay Repairs	***None***	***80%***	***Yes***
Crown Repair	***None***	***80%***	***Yes***
Pulp Capping (excluding final restoration)	***None***	***50%***	***Yes***
Endodontic Services			
Endodontic Therapy (Root canals, etc.)	***None***	***50%***	***Yes***
Root Canal Retreatment	***None***	***50%***	***Yes***
Apicoectomy/Periradicular (Root Surgery)	***None***	***50%***	***Yes***
Guided Tissue Regeneration	***None***	***50%***	***Yes***
Periodontal Services			
Surgical Periodontics	***None***	***50%***	***Yes***
Non-Surgical Periodontics	***None***	***80%***	***Yes***
Periodontal Maintenance	***None***	***80%***	***Yes***
Local Chemotherapeutic Agents	***None***	***80%***	***Yes***
Prosthodontic Services			
Removable Complete and Partial Dentures	***None***	***50%***	***Yes***
Fixed Partial Dentures (Bridges)	***None***	***50%***	***Yes***
Adjustments of Complete and Partial Dentures	***None***	***80%***	***Yes***
Tissue Conditioning	***None***	***50%***	***Yes***
Removal of Teeth			
Simple Extractions	***None***	***80%***	***Yes***
Surgical Removal	***None***	***50%***	***Yes***
Adjunctive General Services			
Consultations	***None***	***100%***	***No***
General Anesthesia, Nitrous Oxide and/or IV Sedation	***None***	***80%***	***Yes***
Injections of Therapeutic Drugs	***None***	***80%***	***Yes***

Service Category	Waiting Period	Plan Pays	Deductible Application
Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed	***None***	***80%***	***Yes***
Palliative Treatment (Emergency)	***None***	***80%***	***Yes***
Occlusal Adjustments	***None***	***80%***	***Yes***
Orthodontic Services			
Cosmetic Orthodontic Services	***None***	***50%***	***No***

Deductibles & Maximums

- *$75 per calendar year Deductible per Member not to exceed $225 per family*
- *$1,500 per calendar year Maximum per Member*
- *$2,500 lifetime Maximum per Member for Orthodontic Services*

UNITED CONCORDIA INSURANCE COMPANY

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – The following services, supplies or charges are excluded:

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (for example but not limitation, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).
3. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.
4. For prescription and non-prescription drugs, vitamins or dietary supplements.
5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.
6. Which are Cosmetic in nature as determined by the Company (for example but not limitation, bleaching, whitening, personalization of crowns).
7. Elective procedures.
8. Procedures performed when poor prognosis is indicated.
9. Those procedures considered experimental and investigational based on current standards of dental treatment.
10. Those performed for the comfort and convenience of the Member or provider.
11. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).
12. For dental implant services unless specifically covered under the Schedule of Benefits or a Rider.
13. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate in the Schedule of Benefits or a Rider. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
14. For treatment of fractures and dislocations of the jaw.
15. For treatment of malignancies or neoplasms.
16. Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation or reconstruction, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
17. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
18. Periodontal splinting of teeth by any method.
19. For duplicate dentures, prosthetic devices or any other duplicative device.
20. For which in the absence of insurance the Member would incur no charge.
21. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
22. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.
23. For treatment and appliances for bruxism (night grinding of teeth).
24. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.
25. Incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).
26. Procedures that are part of a service but are reported as separate services.
27. Procedures that are reported in a treatment sequence that is not appropriate or categorized as "misreported."
28. Procedures that are misreported or that represent a procedure other than the one reported.
29. Specialized procedures and techniques (for example but not limitation, laser assisted new attachment procedure; laser

assisted peri-implantitis procedure; laser decontamination).

30. Fees for broken appointments.
31. Those specifically listed on the Schedule of Benefits as “Not Covered” or “Plan Pays 0%”.
32. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.

LIMITATIONS – Covered services are limited as detailed below. Services are covered until 12:00 a.m. of the birthday when the patient reaches any stated age:

1. Full mouth x-rays – one (1) full mouth x-ray every 60 months.
2. Bitewing x-rays – one (1) set(s) per 1 calendar year(s).
3. Oral Evaluations:
   - Comprehensive and periodic – two (2) of these services per 12 months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
   - Limited problem focused and consultations – (2) of these services per dentist per patient per 12 months.
   - Detailed problem focused – one (1) per dentist per patient per 12 months per eligible diagnosis.
4. Screenings, including state or federally mandated screenings, to determine an individual’s need to be seen by a dentist for diagnosis –once every 6 months.
5. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment) – once every 6 months.
6. Collection and preparation of genetic and/or saliva sample material for laboratory analysis and report – no more than once per lifetime each.
7. Prophylaxis – two (2) per 12 months.
8. Fluoride treatment – two (2) per 12 months under age nineteen (19).
9. Space maintainers – one (1) per three (3) year period for Members under age sixteen (16) when used to maintain space as a result of prematurely lost teeth that have not, or will not, develop.
10. Sealants or sealant repairs – one (1) per tooth per 60 months under age sixteen (16) on permanent first and second molars.
11. Prefabricated crowns – one (1) per tooth per lifetime for Members under age fifteen (15).
12. Periodontal Services:
    - Full mouth debridement – one (1) per lifetime.
    - Periodontal maintenance following active periodontal therapy – two (2) per 1 calendar year(s).
    - Periodontal scaling and root planing – one (1) per 24 months per area of the mouth.
    - Surgical periodontal procedures – one (1) per 24 months per area of the mouth.
    - Guided tissue regeneration – one (1) per tooth per lifetime.
13. Restorative services:
    - Labial veneers – once per tooth per 10 year(s).
14. Replacement of restorative services only when they are not, and cannot be made, serviceable:
    - Basic restorations – not within 12 months of previous placement of any basic restoration unless a new surface of decay is identified on the tooth.
    - Single crowns, inlays, onlays – not within 10 year(s) of previous placement of any of the procedures in this category.
    - Buildups and post and cores – not within 10 year(s) of previous placement of any of the procedures in this category.
    - Replacement of natural tooth/teeth in an arch – not within 10 year(s) of a fixed partial denture, full denture or partial removable denture.
    - Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.

15. Tissue conditioning – once in a 36-month period.
16. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every 24 months thereafter.
17. Pulpal therapy – one (1) per primary tooth per lifetime only when there is no permanent tooth to replace it.
18. Root canal retreatment – one (1) per tooth per lifetime.
19. Recementation – one (1) per 12 months. Recementation during the first 12 months following insertion any preventive, restorative or prosthodontic service by the same dentist is included in the preventive, restorative or prosthodontic service benefit.
20. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.
21. One orthodontic benefit is paid per eligible Member per lifetime. Orthodontic benefit based on treatment plan submitted by Your dentist. Payment for orthodontic services, if covered, shall cease at the end of the month after termination by the Company.
22. Intraoral films:
    - Periapical – four (4) per 12 months per dentist if not performed in conjunction with definitive procedure(s).
    - Occlusal – one (1) per 12 months under age eight (8).
23. General anesthesia and IV sedation: a total of 60 minutes per session.
24. Coverage for Orthodontics is limited to Dependent children under the age of 19.
25. Occlusal adjustments – once every 12 months.

United Concordia

Rider to Schedule of Benefits and Schedule of Exclusions and Limitations

Implantology Rider

This Rider is effective on the date issued to the Policyholder and is attached to and made a part of the Certificate of Insurance.

Except where specifically changed by this Rider, all of the terms and conditions of Your Plan's Certificate of Insurance, Schedule of Benefits and Schedule of Exclusions and Limitations also apply to this Rider. In the event of a conflict between the provisions in this Rider and the Certificate of Insurance, Schedule of Benefits or Schedule of Exclusions and Limitations, this Rider shall control.

SCHEDULE OF BENEFITS

The Company will pay implantology benefits for eligible Members for the following Covered Services equal to 50% of the Maximum Allowable Charge.

Implantology Services

Implant Placement

- Endosteal
- Eposteal
- Transosteal
- Mini

Surgical Services

- Second stage implant surgery
- Implant removal
- Debridement of periimplant defects
- Debridement and osseous contouring of periimplant defect
- Bone graft at time of implant placement

Supporting Structures

- Connecting bar
- Prefabricated abutment
- Custom fabricated abutment

Implant/Abutment Supported Prosthetics

- Removable Dentures
- Fixed Dentures (Hybrid Prosthesis)
- Single Crowns
- Fixed Partial Dentures

Other Implant Related Procedures

- Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla
- Sinus augmentation, lateral open approach
- Sinus augmentation, vertical approach
- Bone replacement graft for ridge preservation

Deductible(s)

The annual Deductibles indicated on the Schedule of Benefits will be applied to implantology services.

Maximum(s)

The annual Maximum indicated on the Schedule of Benefits will be applied to implantology services.

Waiting Period(s)

No Waiting Period will be applied to implantology services.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

The Schedule of Exclusions and Limitations is amended as follows:

Exclusions

Any exclusions relating to implantology services are deleted.

Limitations

The following limitation does not apply to the above listed implantology procedures:

> An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist.

The following limitations are added to the Schedule of Exclusions and Limitations:

> All implantology services are limited to Member's age eighteen (18) and older.
>
> All implantology services (not inclusive of prosthetics) are limited to one (1) per tooth per lifetime.
>
> Implant prosthetics limited to one (1) per ten (10) years.
>
> Mini implants limited to one (1) per tooth per lifetime and a maximum of four (4) per arch per lifetime, in support of a complete removable denture.



Officer's Signature

UNITED CONCORDIA INSURANCE COMPANY

Tuition Reward Program Endorsement

This Endorsement is effective on the Policy Effective Date to the Policyholder and is attached to and made a part of the Group Policy. Capitalized terms not otherwise defined in this Endorsement are defined in the Certificate of Insurance.

As a Certificate Holder enrolled in this United Concordia Group Policy, You are eligible for the College Tuition Reward Program (the "Program"). The Program is not a United Concordia Insurance Company ("United Concordia") product. It is offered to United Concordia Certificate Holders through an arrangement with SAGE CTB LLC ("SAGE"). SAGE, not United Concordia, is solely responsible for the Program, including maintaining the network of participating private colleges and universities, determining reward credits, record keeping, and administration of this Program. United Concordia assumes no liability for the services provided under this Program.

How to Earn College Tuition Rewards
The Program allows each Certificate Holder to accumulate points ("Tuition Rewards") that can be applied toward the full tuition cost for students attending colleges and universities that participate in the SAGE Scholars, Inc. network. Subject to Sage's terms and conditions, each earned Tuition Reward is equivalent to one dollar ($1.00) of tuition reduction that may be used to offset the full tuition bill at participating colleges and universities. Tuition Reward Account balances have no cash value and terms and conditions apply to their use.

Tuition Rewards are accumulated and distributed to eligible students according to SAGE terms and conditions. Please refer to the current SAGE terms and conditions for complete details or contact SAGE's customer service for additional information.

Important dates and time frames related to the use of accumulated Tuition Rewards include the following.

- When the Certificate Holder has a registered 11th grade student, SAGE will email the Certificate Holder instructions for activating the Tuition Rewards account for that student.
- The Certificate Holder must complete SAGE's online activation process before August 24th of the student's 12th grade year.
- Within ten (10) days of applying to a participating college, the Certificate Holder or student must submit a Tuition Rewards statement to the participating college.

Refer to the program instructions provided by SAGE for further details related to Tuition Rewards.

Participating Colleges and Universities:
SAGE maintains a network of participating colleges and universities that accept its Tuition Rewards. All participating institutions are accredited, four-year, not-for-profit, colleges and universities. The list of participating institutions is maintained at the following website:
https://secure.tuitionrewards.com/index.cfm?p=colleges.
SAGE cannot guarantee the continued participation of any specific college in the future.

Tuition Rewards Program Information and Questions:
For additional information related to the SAGE Tuition Rewards Program or the SAGE Scholars, Inc. college network, contact SAGE directly by telephone at (844) 244-4086 or in writing at the address below:

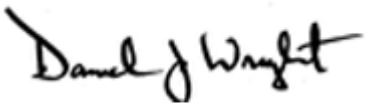
434 Devon Park Drive
Building 400, Suite 410
Wayne, PA 19087
www.collegetuitionbenefit.com

All disputes with regard to the Tuition Rewards program will be settled in accordance with SAGE's terms and conditions and program rules.

Termination:
Certificate Holders registered with SAGE retain the rights to their earned Tuition Rewards after their coverage under this United Concordia Group Policy ends. In the event United Concordia and SAGE discontinue this offering for any reason, Tuition Rewards earned prior to the date the program is discontinued will continue in force and may be used by the Certificate Holder's eligible students in accordance with SAGE's terms and conditions.

Certificate Holders may terminate participation in the College Tuition Rewards Program at any time by providing notice of intent to terminate to SAGE. Termination of participation status with SAGE does not affect eligibility for Covered Services under this Group Policy. To terminate participation in the College Tuition Rewards Program, send a notice by email to support@sagescholars.com or by regular mail to SAGE Scholars Inc., 1600 Arch Street, Suite 2502, Philadelphia, PA 19103.

General:
The terms and conditions related to the College Tuition Reward Program described by this Endorsement do not change the dental Plan's Group Policy and Certificate of Insurance, to which this Endorsement is attached. In the event of a conflict between the provisions in this Endorsement and the Certificate of Insurance or Group Policy, the Certificate of Insurance or Group Policy will control. Some states and/or jurisdictions may not permit use of this program for individuals under their jurisdiction.



Officer Signature

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

The Plan:

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

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

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

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

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

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

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-332-0366 (TTY: 711).
Español (Spanish)	ATENCIÓN: Si habla español, le ofrecemos servicios gratuitos de asistencia lingüística. Llame al 1-800-332-0366 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-0366 (TTY: 711)。
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-800-332-0366 (TTY: 711).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-0366 (TTY: 711) 번으로 전화해 주십시오.
Tagalog (Tagalog - Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-332-0366 (TTY: 711).
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните 1-800-332-0366 (телетайп: 711).
العربية (Arabic)	يرجى الانتباه: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة للغوية المجانية. اتصل على 1-800-332-0366 (TTY: 711)
Kreyòl Ayisyen (French Creole)	ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis èd nan lang ki disponib gratis pou ou. Rele nimewo 1-800-332-0366 (TTY: 711).
Français (French)	ATTENTION : si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Appelez le 1-800-332-0366 (ATS: 711).
Polski (Polish)	UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-0366 (TTY: 711).
Português (Portuguese)	ATENÇÃO: se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-800-332-0366 (TTY: 711).
Italiano (Italian)	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-332-0366 (TTY: 711).
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Dienste für die sprachliche Unterstützung zur Verfügung. Rufnummer: 1-800-332-0366 (TTY: 711).
日本語 (Japanese)	注意事項：日本語をお使いの方は、言語面でのサポートを無償でご利用いただけます。1-800-332-0366（TTY: 711）まで、お電話にてご連絡ください。
فارسی (Farsi)	توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید. 1-800-332-0366 (TTY: 711)

United Concordia dental℠

UNITED CONCORDIA INSURANCE COMPANY

1800 Center Street, Suite 2B 220
Camp Hill, PA 17011

Dental Plan
Certificate of Insurance

EFFINGHAM COUNTY BOARD OF EDUCATION
926682000, 926682001, 926682006, 926682007, 926682099, 926682399
January 1, 2025

United Concordia Dental policies are underwritten by
United Concordia Insurance Company

CERTFICATE OF INSURANCE

INTRODUCTION

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

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

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

800-332-0366

For general information, Participating Dentist or benefit information, You may also log on to our website at:

www.unitedconcordia.com

Claim forms should be sent to:

United Concordia Companies, Inc.
Dental Claims
PO Box 69421
Harrisburg, PA 17106-9421

TABLE OF CONTENTS

DEFINITIONS 4
ELIGIBILITY AND ENROLLMENT 6
HOW THE DENTAL PLAN WORKS 8
BENEFITS 9
TERMINATION 12
CONTINUATION OF COVERAGE 13
GENERAL PROVISIONS 13

Attached:

Appeal Procedure Addendum
Schedule of Benefits
Schedule of Exclusions and Limitations

DEFINITIONS

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

Annual Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during a calendar year or Contract Year as shown on the Schedule of Benefits. When a Member reaches the Annual Maximum, the Company will make no additional payment(s) for Covered Services.

Certificate Holder(s) - An individual who, because of his/her status with the Policyholder, has enrolled him/herself and/or his/her eligible Dependents for dental coverage and for whom Premiums are paid.

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

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

Company - United Concordia, the insurer.

Contract Year- The period of twelve (12) months beginning on the Group Policy's Effective Date or the anniversary of the Group Policy's Effective Date and ending on the day before the Renewal Date.

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

Cosmetic - Services or procedures that are not Dentally Necessary and are primarily intended to improve or otherwise modify the Member's appearance.

Covered Service(s) - Services or procedures shown on the Schedule of Benefits for which benefits will be covered subject to the Schedule of Exclusions and Limitations, when rendered by a Dentist.

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

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

Dentist(s) – A person licensed to practice dentistry in the state in which dental services are provided. Dentist will include any other duly licensed dental professional practicing under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

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

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

1. The Certificate Holder's Spouse and
2. Any natural child, stepchild, adopted child or child placed with the Certificate Holder or the Certificate Holder's Spouse by order of a court or administrative agency:
   (a) until the end of the month that the child reaches age twenty-six (26); or

(b) until the end of the month that the child reaches age twenty-six (26) if he/she is a full-time student at an accredited educational institution and is chiefly reliant upon the Certificate Holder for maintenance and support; or
(c) to any age if the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

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

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

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

Family Policy – A Group Policy that covers the Policyholder's Certificate Holders and may also cover eligible Dependents, as defined in this Certificate. A Group Policy that covers only Certificate Holders is not a Family Policy.

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

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

Lifetime Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during the entire time the Member is enrolled under the Group Policy, as shown on the Schedule of Benefits.

Limitation(s) - The maximum frequency or age limit applied to a Covered Service set forth in the Schedule of Exclusions and Limitations.

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 Us and the particular Participating Dentist rendering the service. Depending upon the Plan purchased by the Policyholder, Maximum Allowable Charges for Covered Services rendered by Non-Participating Dentists may be the same or higher than such charges for Covered Services rendered by Participating Dentists in order to help limit Out-of-Pocket Expenses of Members choosing Non-Participating Dentists.

Member(s) – Enrolled Certificate Holder(s) and their enrolled Dependent(s). Also referred to as "You" or "Your" or "Yourself".

Non-Participating Dentist - A Dentist who has not signed a contract with Us to accept the Company's Maximum Allowable Charges as payment in full for Covered Services.

Out-of-Pocket Expense(s) – Costs not paid by Us, including but not limited to Coinsurance, Deductibles, amounts billed by Non-Participating Dentists that are over the Maximum Allowable Charge, costs of services that exceed the Policy's Limitations or Maximums, or for services that are Exclusions. The Certificate Holder is responsible to pay for Out-of-Pocket Expenses.

Participating Dentist - A Dentist who has executed a Participating Dentist Agreement with Us, under which he/she agrees to accept the Company's Maximum Allowable Charges as payment in full for Covered Services. Participating Dentists may also agree to limit their charges for any other services delivered to Members.

Plan - Dental benefits pursuant to this Certificate and attached Schedule of Exclusions and Limitations and Schedule of Benefits.

Policyholder - Organization that executes the Group Policy. Also referred to as "Your Group".

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

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

Schedule of Benefits - Attached summary of Covered Services, Coinsurances, Deductibles, Waiting Periods and maximums applicable to benefits payable under the Plan.

Schedule of Exclusions and Limitations – Attached list of Exclusions and Limitations applicable to benefits, services, supplies or charges under the Plan.

Special Enrollment Period – The period of time outside Your Group's open enrollment period during which eligible individuals who experience certain qualifying events may enroll as Certificate Holders or Dependents in this Group Policy.

Spouse – The Certificate Holder's partner by marriage or by any union between two adults that is recognized by law in the state where this Group Policy is issued.

Teledentistry/Telehealth dental service – A health care service performed by a dentist, or appropriately licensed health care provider acting under the delegation and supervision of a dentist, to a patient who is at a physical location different than the provider using telecommunications or information technology.

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

Waiting Period(s) - A period of time a Member must be enrolled under the Group Policy before benefits will be paid for certain Covered Services as shown on the attached Schedule of Benefits.

We, Our or Us - The Company, its affiliate or an organization with which it contracts for a provider network and/or to perform certain functions to administer this Policy.

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

In order to be a Member, You must meet the eligibility requirements of Your Group and this Group Policy. We must receive enrollment information for the Certificate Holder, enrolled Dependents, and Policyholder. Provided that We receive applicable Premium, coverage will begin on the date specified in the enrollment information We receive. Your Group will inform Certificate Holders of its eligibility requirements.

If You have already satisfied all eligibility requirements on the Group Policy Effective Date and Your enrollment information and applicable Premium are supplied to Us, Your coverage will begin on the Group Policy Effective Date.

If You are not eligible to be a Member on the Group Policy Effective Date, You must supply the required enrollment information on Yourself and any eligible Dependents, as specified in the Definitions section, within thirty-one (31) days of the date You meet all applicable eligibility requirements.

Coverage for Members enrolling after the Group Policy Effective Date 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 teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. Procedures started prior to the Member's Effective Date are the liability of the Member or a prior insurance carrier.

Special Enrollment Periods - Enrollment Changes

After Your Effective Date, You can change Your enrollment during Your Group's open enrollment period. There are also Special Enrollment Periods when the Certificate Holder may add or remove Dependents. These Special Enrollment Period life change events include:

- birth of a child;
- adoption of a child;
- court order of placement or custody of a child;
- change in student status for a child;
- loss of other coverage; or,
- marriage or other lawful union between two adults.

If You enrolled through Your Group, to enroll a new Dependent as a result of one of these events, You must supply the required enrollment change information within the Special Enrollment Period that is thirty-one (31) days from the date of the life change event. The Dependent must meet the definition of Dependent applicable to this Group Policy.

Except for newly born or adoptive children, coverage for the new Dependent will begin on the date specified in the enrollment information provided to as long as the Premium is paid.

Newly born children of a Member will be considered enrolled from the moment of birth. Adoptive children will be considered enrolled from the date of adoption or placement, except for those adopted or placed within thirty-one (31) days of birth who will be considered enrolled Dependents from the moment of birth. In order for coverage of newly born or adoptive children to continue beyond the first thirty-one (31) day period, the child's enrollment information must be provided to Us and the required Premium must be paid within the first thirty-one (31) day period in which coverage is effective.

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 ninety (90) days after the child 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 thirty (30) days after the child 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 thirty (30) days after the Dependent attains the limiting age for students. Such evidence will be requested thereafter based on information provided by the Member's physician, but no more frequently than annually.

Dependent coverage may only be terminated when certain life change events occur including death, divorce or dissolution of the union or domestic partnership, reaching the limiting age or during open enrollment periods or when otherwise permitted by any applicable law or regulation.

Late Enrollment

If You or Your Dependents are not enrolled within thirty-one (31) days of initial eligibility or during the Special Enrollment Period specified for a life change event, You or Your Dependents cannot enroll until the next Special Enrollment Period or open enrollment period conducted for Your Group. If You are required by court order to provide coverage for a Dependent child, You will be permitted to enroll the Dependent child without regard to enrollment season restrictions.

HOW THE DENTAL PLAN WORKS

Choice of Provider

You may choose any licensed Dentist for services. However, Your Out-of-Pocket Expenses will vary depending upon whether or not Your Dentist is in Our network. If You choose a Participating Dentist, You may limit Your Out-of-Pocket Expense. Participating Dentists agree by contract to accept Maximum Allowable Charges as payment in full for Covered Services. Also, if agreed by the provider, Participating Dentists limit their charges for all services delivered to Members, even if the service is not covered for any reason and a benefit is not paid under this Plan. Participating Dentists also complete and send claims directly to Us for processing. To find a Participating Dentist, visit Our website at www.unitedconcordia.com or call Us at the toll-free number in the Introduction section of this Certificate or on Your ID card.

If You use a Non-Participating Dentist, You may have to pay the Dentist at the time of service, complete and submit Your own claims and wait for Us to reimburse You. You will be responsible for the Dentist's full charge which may exceed Our Maximum Allowable Charge and result in higher Out-of-Pocket Expenses.

Notice of Claims

Written notice of claim must be given to the Company within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Member to the Company, or to any authorized agent of the Company, with information sufficient to identify the Member, shall be deemed notice to the Company.

Claim Forms

The Company, upon receipt of a notice of claim, will furnish to the Member such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 10 days after the Company received notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

The Company will provide claim forms to and accept claims for filing proof of loss submitted by a custodial parent of an eligible Dependent child who is the subject of a court or administrative order relating to provision of health care coverage. If services are provided by a Non-Participating Dentist, the Company will make payments directly to such custodial parent or to the Department of Public Welfare if benefits are payable under Medical Assistance.

Proof of Loss

Written proof of loss must be furnished to the Company at its said office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 30 days after the termination of the period for which the Company is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

The acknowledgment by the Company of the receipt of notice given or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the Company in defense of any claim arising under such policy.

Time Payment of Claims

All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid no later than 30 days and acknowledge no later than 15 days from receipt of due written proof of such loss. The Company may extend this 30-day period by no more than 15 days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Company. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid quarterly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. Benefits not paid in accordance with this provision, Company shall pay 18 percent per annum on the proceeds overdue under the Plan for benefits not paid in accordance with this provision.

Physical Examinations

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

BENEFITS

Covered Services

Benefits and any applicable Coinsurance, Deductibles, Annual Maximums, Lifetime Maximums, Out-of-Pocket Maximums and Waiting Periods are shown on the attached Schedule of Benefits. Covered Services shown on the Schedule of Benefits must be Dentally Necessary unless otherwise specified in a Rider to this Group Policy and are subject to frequency or age Limitations detailed on the attached Schedule of Exclusions and Limitations.

No benefits will be paid for services, supplies or charges detailed under the Exclusions on the Schedule of Exclusions and Limitations, and no benefits will be paid for services on the Schedule of Benefits with a Coinsurance of zero (0).

TeleDentistry

Covered Services provided through Teledentistry are reimbursed on the same basis and to the same extent as coverage for the services provided in an in-person setting. Coverage is without regard to whether the service is provided in an in-person setting or virtually (i.e. through teledentistry). Covered Services provided through teledentistry accumulate to Your Annual Maximum, Deductible and frequency limitations, as applicable.

In order to receive Covered Services in a virtual setting, You will need an internet-ready device capable of running applications used in the provision of telehealth services. Teledentistry services can be provided to Members age 13 and above. Members age 12 and under will require adult supervision and consent in order to receive services through teledentistry.

Predetermination

A predetermination is a request for Us to estimate benefits for a dental treatment You have not yet received. Predetermination is not required for any benefits under the Plan. In estimating benefits, We look at patient eligibility, Dental Necessity and the Plan's coverage for the treatment. Payment of benefits for a predetermined service is subject to Your continued eligibility in the Plan. At the time the claim is paid, We may also correct mathematical errors, apply coordination of benefits, and make adjustments to comply with Your current Plan and applicable Annual Maximums, Lifetime Maximums, or Out-of-Pocket Maximums on the date of service.

Payment of Benefits

If You have treatment performed by a Participating Dentist, We will pay covered benefits directly to the Participating Dentist. Both You and the Dentist will be notified of benefits covered, Our payment and any

Out-of-Pocket Expenses. Payment will be based on the Maximum Allowable Charge Your Participating Dentist has contracted to accept. Maximum Allowable Charges may vary depending on the geographical area of the dental office and the contract between Us and the particular Participating Dentist rendering the service. **Benefits for covered dental emergency services provided by a Non-Participating Dentist will be paid at the same level that would have been paid had the services been rendered by a Participating Dentist.**

If You receive treatment from a Non-Participating Dentist, We will send payment for Covered Services to You unless You the claim indicates that payment should be sent directly to Your treating Dentist. This is called assignment of benefits. You will be notified of the services covered, Our payment and any Out-of-Pocket Expenses. You will be responsible to pay the Dentist any difference between Our payment and the Dentist's full charge for the services. Non-Participating Dentists are not obligated to limit their fees to Our Maximum Allowable Charges.

We are not liable to pay benefits for any services started prior to a Member's Effective Date of coverage. Multi-visit procedures are considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. Procedures started prior to the Member's Effective Date are the liability of the Member.

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

Overpayments

When We make an overpayment for benefits, We have the right to recover the overpayment either from You or from the person or Dentist to whom it was paid. We will recover the overpayment either by requesting a refund or offsetting the amount overpaid from future claim payments. This recovery will follow any applicable state laws or regulations. The Member must provide any assistance necessary, including furnishing information and signing necessary documents, for the Company to be reimbursed.

Coordination of Benefits (COB)

If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, benefits will be coordinated. This means that one plan will be primary and determine its benefits before those of the other plan, and without considering the other plan's benefits. The other plan will be secondary and determine its benefits after the primary plan. The secondary plan's benefits may be reduced because of the primary plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this Plan will determine payment.

1. When used in this Coordination of Benefits section, the following words and phrases have the definitions below:

    A) **Allowable Amount** is the Plan's allowance for items of expense, when the care is covered at least in part by one or more Plans covering the Member for whom the claim is made.
    B) **Claim Determination Period** means a benefit year. However, it does not include any part of a year during which a person has no coverage under this Plan.
    C) **Other Dental Plan** is any form of coverage which is separate from this Plan with which coordination is allowed. **Other Dental Plan** will be any of the following which provides dental benefits, or services, for the following: Group insurance or group type coverage, whether insured or uninsured. It also includes coverage other than school accident type coverage (including grammar, high school and college student coverages) for accidents only, including athletic injury, either on a twenty-four (24) hour basis or on a "to and from school basis," or group or group type hospital indemnity benefits of $100 per day or less.
    D) **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.

E) **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.
F) **Plan** means this document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.

2. The fair value of services provided by the Company will be considered to be the amount of benefits paid by the Company. The Company will be fully discharged from liability to the extent of such payment under this provision.

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

A) If the other plan does not have a provision similar to this one, then that plan will be primary.
B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.
C) Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:
    1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
    2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
    3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
    4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
D) Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:
    1) First, the plan of the parent with custody of the child.
    2) Then, the plan of the Spouse of the parent with the custody of the child; and
    3) Finally, the plan of the parent not having custody of the child.
    4) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
    5) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 3-C) above, titled Dependent Child/Parents Not Separated or Divorced.
E) Active/Inactive Member
    1) For actively employed Members and their Spouses over the age of sixty-five (65) who are covered by Medicare, the plan will be primary.
    2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.
F) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary.
G) The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a Member or a Dependent.

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

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

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

Review of a Benefit Determination

If You are not satisfied with a benefit determination or payment, please contact Our Customer Service Department at the toll-free telephone number in the Introduction section of this Certificate or on Your ID card. If, after speaking with a Customer Service representative, You are still dissatisfied, refer to the Appeal Procedure Addendum attached to this Certificate for further steps You can take regarding Your claim.

Value-Added Programs and Services

From time to time, We offer Members access to various lifestyle, health and/or value-added programs and services. Such offerings are subject to change at any time without notice. Contact Your Group or call Customer Service for eligibility requirements and other information. Eligibility requirements for these programs and services are applied in a uniform, non-discriminatory manner to all Members.

TERMINATION -- WHEN COVERAGE ENDS

A Member's coverage will end:

- when You no longer meet Your Group's eligibility requirements; or
- when Premium payment ceases for You; or
- when you no longer meet the eligibility requirements for a Dependent, as defined in the Definitions section of this Certificate.

On the date the Certificate Holder's coverage ends or the Certificate Holder is no longer eligible to enroll his/her Dependents, Dependent coverage will end unless otherwise specified in any applicable addendum or endorsement to this Certificate. If the Group Policy is cancelled, Certificate Holder and Dependent coverage will end on the Group Policy Termination Date.

If the Policyholder fails to pay Premium, coverage will remain in effect during the Grace Period. If the Premium is not received by the end of the Grace Period, the Group Policy will be cancelled and coverage will terminate on the last date for which Premium was paid.

Benefits After Coverage Terminates

We are not liable to pay any benefits for services, including those predetermined, that are started after Your Termination Date or after the Group Policy Termination Date. However, coverage for completion of a dental procedure requiring two (2) or more visits on separate days will be extended for a period of ninety (90) days after the Termination Date in order for the procedure to be finished. The procedure must be started prior to the Termination Date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Member's Termination Date. This extension does not apply if the Group Policy terminates for failure to pay Premium.

CONTINUATION COVERAGE

Federal or state law may require that certain employers offer continuation coverage to Members for a period of time upon the Certificate Holder's reduction of work hours or termination of employment for any reason other than gross misconduct. Contact Your Group to find out if this applies to You. Your Group will advise You of Your rights to continuation coverage and the cost. If applicable, You must elect to continue coverage within sixty (60) days from Your qualifying event or from notification of rights by Your Group, whichever is later. Dependents may have separate election rights, or You may elect to continue coverage for them. You must pay the required premium for continuation coverage directly to Your Group. The Company is not responsible for determining who is eligible for continuation coverage.

GENERAL PROVISIONS

The failure of any section or subsection of this Certificate shall not affect the validity, legality and enforceability of the remaining sections.

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

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

This Certificate will be construed for all purposes as a legal document and will be interpreted and enforced in accordance with pertinent laws and regulations of Georgia.

Legal Actions

No action at law or inequity shall be brought to recover on this Certificate prior to the expiration of 60 days after a claim has been filed in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of 3 years after the time a claim is required to be filed.

Right of Recovery

If You or Your covered Dependent has a claim for damages or a right to recover damages from a third party or parties for any illness or injury for which benefits are payable under this Plan, the Company may have a right of recovery. Our right of recovery shall be limited to the recovery of any benefits paid for identical Covered Services under this Plan, but shall not include non-dental items. Money received for future dental care or pain and suffering may not be recovered. The Company's right of recovery may include compromised settlements. You or Your attorney must inform the Company of any legal action or settlement agreement at least 10 days prior to settlement or trial. The Company will notify You of the amount it seeks to recover for covered benefits paid. Our recovery may be reduced by the pro-rata share of Your attorney's fees and expenses of litigation.

ADDENDUM TO CERTIFICATE

APPEAL PROCEDURE

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

If You are dissatisfied with Our benefit determination on a claim, You or Your Authorized Representative may appeal Our decision by following the steps outlined in this procedure. We will resolve Your appeal in a thorough, appropriate, and timely manner to ensure that You are afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the Plan documents and consistently among claimants. You or Your Authorized Representative may submit written comments, documents, records and other information relating to claims or appeals. We will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by Us required under these procedures will be supplied to You or Your Authorized Representative.

DEFINITIONS

The following terms when used in this document have the meanings shown below.

"Adverse Benefit Determination" is a denial, reduction, or termination of or failure to make payment (in whole or in part) for a Claim for Benefits based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is Experimental or Investigational, not Dentally Necessary, not Medically Necessary or not appropriate.

"Authorized Representative" is a person granted authority by You and the Company to act on Your behalf regarding a Claim for Benefits or an appeal of an Adverse Benefit Determination. An assignment of benefits is not a grant of authority to act on Your behalf in pursuing and appealing a benefit determination.

"Claim for Benefits" is a request for a plan benefit or benefits by You in accordance with the Plan's reasonable procedure for filing benefit claims, including Pre-service and Post-service Claims.

"Pre-service Claim" is a Claim for Benefits under the Plan when the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

"Post-service Claim" ("Claim") is any Claim for Benefits under a group health plan that is not a Pre-service Claim.

"Relevant" A document, record, or other information will be considered "**relevant**" to a given claim:

a) if it was relied on in making the benefit determination;
b) if it was submitted, considered, or generated in the course of making the benefit determination (even if the Plan did not rely on it);
c) if it demonstrated that, in making the determination, the Plan followed its own administrative processes and safeguards for ensuring appropriate decision-making and consistency;
d) or if it is a statement of the Plan's policy or guidance concerning the denied benefit, without regard to whether it was relied upon in making the benefit determination.

PROCEDURE FOR PRE-SERVICE CLAIM

You or Your Authorized Representative have 180 days from the date You or Your Authorized Representative received notice of the Adverse Benefit Determination to appeal the decision. To file an appeal, call the toll-free telephone number listed in Your Certificate of Coverage or on Your ID card.

The dentist advisor involved in the appeal will be different from and not a subordinate of the dentist advisor involved in the adverse determination on initial Claim for Benefits. We will provide You or Your Authorized Representative with written or electronic notice of Our appeal decision within 30 days of the request to review the Adverse Benefit Determination. The notice of Our appeal decision will include the following:

a) The specific reason for the appeal decision;
b) A reference to specific plan provisions on which the decision was based;
c) A statement that You or Your Authorized Representative is entitled reasonable access to and copies of all relevant documents, records, and criteria. This includes an explanation of clinical judgment on which the decision was based and identification of the dental experts. All such information is available upon request and is free of charge.
d) A statement of Your or Your Authorized Representative's right to bring a civil action under ERISA; and
e) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

PROCEDURE FOR POST-SERVICE CLAIM

You or Your authorized representative may file an appeal with Us within 180 days of receipt of an adverse benefit determination. To file an appeal, telephone the toll-free number listed in Your Certificate of Insurance or on Your ID card.

We will review the claim and notify You of Our decision within 60 days of the request for appeal. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination.

Notice of the appeal decision will include the following in written or electronic form:

a) the specific reason for the appeal decision;
b) reference to specific plan provisions on which the decision was based;
c) a statement that You are entitled to receive reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts; All such information is available upon request and is free of charge.
d) a statement of Your right to bring a civil action under ERISA; and
e) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
f) The option of seeking an independent review through a certified independent review agent if the service is greater than $500.00 33-20A-33.

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 INSURANCE COMPANY

ADDENDUM

TO

GROUP POLICY AND CERTIFICATE OF INSURANCE

This Addendum is effective on the Effective Date as stated in the Group Policy and attached to and made part of the Group Policy and Certificate of Insurance.

The following language is added to the Group Policy and Certificate of Insurance:

> The Company uses Maximum Allowable Charge schedules to determine claim payments. Payment is the lesser of the dentist's submitted charge or the Maximum Allowable Charge.
>
> In-Network Maximum Allowable Charges for Covered Services are determined by geographical area of the dental office or otherwise negotiated. The In-Network Maximum Allowable Charges in the geographical area of the dental office are used to calculate the Company's payment on claims. In-Network Maximum Allowable Charges are reviewed periodically and adjusted as appropriate to reflect increased dentist fees within the geographical areas. Participating Dentists accept their contracted Maximum Allowable Charges as payment in full for Covered Services.
>
> Out-of-Network Maximum Allowable Charges are derived from a targeted percentile of dentist charges for Covered Services by grouping the 90th percentile of dentist charges into different geographical areas. The Out-of-Network Maximum Allowable Charges at the indicated percentile in the geographical area of the dental office are used to calculate the Company's payment on Non-Participating Dentist claims. The source of the dentist charge data is select charge data purchased by the Company supplemented where necessary by internal claim data. Out-of-Network Maximum Allowable Charges are calculated at a set point of time and updated periodically.

United Concordia Insurance Company

Schedule of Benefits

Concordia Flex[sm]

Group Name: Effingham County Board of Education
Group Number(s): 926682000, 926682001, 926682006, 926682007, 926682099, 926682399
Effective Date: January 1, 2025

The grid below provides information related to Covered Services under this Plan. If a service is a Covered Service, a percentage greater than zero in the column titled "Plan Pays" will be indicated. If a Covered Service has a Waiting Period, the Waiting Period will be listed in the column titled "Waiting Period." Some services will be covered in full prior to the Deductible being met. If this is the case, the "Deductible Application" column will indicate "no." If the Deductible must be met prior to a service being covered at the indicated coinsurance, then "yes" will appear in the "Deductible Application column. Only Covered Services are subject to reimbursement. All services on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations. Consult Your Certificate for more details on the services listed. Riders may affect coverage levels. Participating Dentists accept the Maximum Allowable Charge as payment in full.

Service Category	Waiting Period	Plan Pays	Deductible Application
Diagnostic Services			
Oral Evaluations (Exams)	***None***	***100%***	***No***
Screenings and Patient Assessments	***None***	***100%***	***No***
Pulp Vitality Tests and Bacteriological Studies	***None***	***80%***	***Yes***
Collection and preparation of genetic and saliva sample material for laboratory analysis and report	***None***	***80%***	***Yes***
Diagnostic Casts	***None***	***80%***	***Yes***
Radiographs (X-Rays)			
Bitewings	***None***	***100%***	***No***
Full Mouth	***None***	***80%***	***Yes***
Occlusal Films	***None***	***100%***	***No***
Preventive Services			
Prophylaxis (Cleanings)	***None***	***100%***	***No***
Fluoride	***None***	***100%***	***No***
Sealants and Sealant Repairs	***None***	***80%***	***Yes***
Space Maintainers	***None***	***100%***	***No***
Restorative Services			
Restorations *	***None***	***80%***	***Yes***
Single Crowns	***None***	***0%***	***N/A***

Service Category	Waiting Period	Plan Pays	Deductible Application
Single Implant Crowns	***None***	***0%***	***N/A***
Stainless Steel Crowns *	***None***	***80%***	***Yes***
Inlays	***None***	***0%***	***N/A***
Onlays	***None***	***0%***	***N/A***
Inlay Repairs	***None***	***80%***	***Yes***
Onlay Repairs	***None***	***80%***	***Yes***
Crown Repair	***None***	***80%***	***Yes***
Pulp Capping (excluding final restoration)	***None***	***0%***	***N/A***
Endodontic Services			
Endodontic Therapy (Root canals, etc.)	***None***	***0%***	***N/A***
Root Canal Retreatment	***None***	***0%***	***N/A***
Apicoectomy/Periradicular (Root Surgery)	***None***	***0%***	***N/A***
Guided Tissue Regeneration	***None***	***0%***	***N/A***
Periodontal Services			
Surgical Periodontics	***None***	***0%***	***N/A***
Non-Surgical Periodontics	***None***	***0%***	***N/A***
Periodontal Maintenance	***None***	***0%***	***N/A***
Local Chemotherapeutic Agents	***None***	***0%***	***N/A***
Prosthodontic Services			
Removable Complete and Partial Dentures	***None***	***0%***	***N/A***
Fixed Partial Dentures (Bridges)	***None***	***0%***	***N/A***
Adjustments of Complete and Partial Dentures	***None***	***80%***	***Yes***
Tissue Conditioning	***None***	***0%***	***N/A***
Removal of Teeth			
Simple Extractions	***None***	***80%***	***Yes***
Surgical Removal	***None***	***0%***	***N/A***
Adjunctive General Services			
Consultations	***None***	***100%***	***No***
General Anesthesia, Nitrous Oxide and/or IV Sedation	***None***	***80%***	***Yes***
Injections of Therapeutic Drugs	***None***	***80%***	***Yes***

Service Category	Waiting Period	Plan Pays	Deductible Application
Application of desensitizing medicaments where periodontal treatment (including scaling, root planning, and periodontal surgery, such as osseous surgery) has been performed	***None***	***80%***	***Yes***
Palliative Treatment (Emergency)	***None***	***80%***	***Yes***
Occlusal Adjustments	***None***	***80%***	***Yes***
Orthodontic Services			
Cosmetic Orthodontic Services	***None***	***0%***	***N/A***

Deductibles & Maximums

- *$50 per calendar year Deductible per Member not to exceed $150 per family*
- *$500 per calendar year Maximum per Member*

UNITED CONCORDIA INSURANCE COMPANY

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – The following services, supplies or charges are excluded:

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (for example but not limitation, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).
3. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.
4. For prescription and non-prescription drugs, vitamins or dietary supplements.
5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.
6. Which are Cosmetic in nature as determined by the Company (for example but not limitation, bleaching, whitening, personalization of crowns).
7. Elective procedures.
8. Procedures performed when poor prognosis is indicated.
9. Those procedures considered experimental and investigational based on current standards of dental treatment.
10. Those performed for the comfort and convenience of the Member or provider.
11. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).
12. For dental implant services unless specifically covered under the Schedule of Benefits or a Rider.
13. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate in the Schedule of Benefits or a Rider. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
14. For treatment of fractures and dislocations of the jaw.
15. For treatment of malignancies or neoplasms.
16. Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation or reconstruction, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
17. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
18. Periodontal splinting of teeth by any method.
19. For duplicate dentures, prosthetic devices or any other duplicative device.
20. For which in the absence of insurance the Member would incur no charge.
21. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
22. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.
23. For treatment and appliances for bruxism (night grinding of teeth).
24. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.
25. Incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).
26. Procedures that are part of a service but are reported as separate services.
27. Procedures that are reported in a treatment sequence that is not appropriate or categorized as "misreported."
28. Procedures that are misreported or that represent a procedure other than the one reported.

29. Specialized procedures and techniques (for example but not limitation, laser assisted new attachment procedure; laser assisted peri-implantitis procedure; laser decontamination).
30. Fees for broken appointments.
31. Those specifically listed on the Schedule of Benefits as “Not Covered” or “Plan Pays 0%”.
32. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.
33. Orthodontic services, supplies, and appliances.

LIMITATIONS – Covered services are limited as detailed below. Services are covered until 12:00 a.m. of the birthday when the patient reaches any stated age:

1. Full mouth x-rays – one (1) full mouth x-ray every 60 months.
2. Bitewing x-rays – one (1) set(s) per 1 calendar year(s).
3. Oral Evaluations:
    - Comprehensive and periodic – two (2) of these services per 12 months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
    - Limited problem focused and consultations – (2) of these services per dentist per patient per 12 months.
    - Detailed problem focused – one (1) per dentist per patient per 12 months per eligible diagnosis.
4. Screenings, including state or federally mandated screenings, to determine an individual’s need to be seen by a dentist for diagnosis – once every 6 months.
5. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment) – once every 6 months.
6. Collection and preparation of genetic and/or saliva sample material for laboratory analysis and report – no more than once per lifetime each.
7. Prophylaxis – two (2) per 12 months.
8. Fluoride treatment – two (2) per 12 months under age nineteen (19).
9. Space maintainers – one (1) per three (3) year period for Members under age sixteen (16) when used to maintain space as a result of prematurely lost teeth that have not, or will not, develop.
10. Sealants or sealant repairs – one (1) per tooth per 60 months under age sixteen (16) on permanent first and second molars.
11. Prefabricated crowns – one (1) per tooth per lifetime for Members under age fifteen (15).
12. Replacement of restorative services only when they are not, and cannot be made, serviceable: - only basic restorative services are covered the other bullets aren’t bracketed
    - Basic restorations – not within 24 months of previous placement of any basic restoration unless a new surface of decay is identified on the tooth.
    - Buildups and post and cores – not within 5 year(s) of previous placement of any of the procedures in this category.
13. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every 24 months thereafter.
14. Recementation – one (1) per 12 months.
15. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.

16. Intraoral films:
    - Periapical – four (4) per 12 months per dentist if not performed in conjunction with definitive procedure(s).
    - Occlusal – one (1) per 12 months under age eight (8).
17. General anesthesia and IV sedation: a total of 60 minutes per session.
18. Occlusal adjustments – once every 12 months.

UNITED CONCORDIA INSURANCE COMPANY

Tuition Reward Program Endorsement

This Endorsement is effective on the Policy Effective Date to the Policyholder and is attached to and made a part of the Group Policy. Capitalized terms not otherwise defined in this Endorsement are defined in the Certificate of Insurance.

As a Certificate Holder enrolled in this United Concordia Group Policy, You are eligible for the College Tuition Reward Program (the "Program"). The Program is not a United Concordia Insurance Company ("United Concordia") product. It is offered to United Concordia Certificate Holders through an arrangement with SAGE CTB LLC ("SAGE"). SAGE, not United Concordia, is solely responsible for the Program, including maintaining the network of participating private colleges and universities, determining reward credits, record keeping, and administration of this Program. United Concordia assumes no liability for the services provided under this Program.

How to Earn College Tuition Rewards
The Program allows each Certificate Holder to accumulate points ("Tuition Rewards") that can be applied toward the full tuition cost for students attending colleges and universities that participate in the SAGE Scholars, Inc. network. Subject to Sage's terms and conditions, each earned Tuition Reward is equivalent to one dollar ($1.00) of tuition reduction that may be used to offset the full tuition bill at participating colleges and universities. Tuition Reward Account balances have no cash value and terms and conditions apply to their use.

Tuition Rewards are accumulated and distributed to eligible students according to SAGE terms and conditions. Please refer to the current SAGE terms and conditions for complete details or contact SAGE's customer service for additional information.

Important dates and time frames related to the use of accumulated Tuition Rewards include the following.

- When the Certificate Holder has a registered 11th grade student, SAGE will email the Certificate Holder instructions for activating the Tuition Rewards account for that student.
- The Certificate Holder must complete SAGE's online activation process before August 24th of the student's 12th grade year.
- Within ten (10) days of applying to a participating college, the Certificate Holder or student must submit a Tuition Rewards statement to the participating college.

Refer to the program instructions provided by SAGE for further details related to Tuition Rewards.

Participating Colleges and Universities:
SAGE maintains a network of participating colleges and universities that accept its Tuition Rewards. All participating institutions are accredited, four-year, not-for-profit, colleges and universities. The list of participating institutions is maintained at the following website:
https://secure.tuitionrewards.com/index.cfm?p=colleges.
SAGE cannot guarantee the continued participation of any specific college in the future.

Tuition Rewards Program Information and Questions:
For additional information related to the SAGE Tuition Rewards Program or the SAGE Scholars, Inc. college network, contact SAGE directly by telephone at (844) 244-4086 or in writing at the address below:

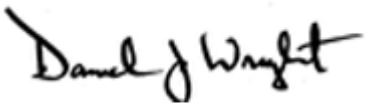
434 Devon Park Drive
Building 400, Suite 410
Wayne, PA 19087
www.collegetuitionbenefit.com

All disputes with regard to the Tuition Rewards program will be settled in accordance with SAGE's terms and conditions and program rules.

Termination:
Certificate Holders registered with SAGE retain the rights to their earned Tuition Rewards after their coverage under this United Concordia Group Policy ends. In the event United Concordia and SAGE discontinue this offering for any reason, Tuition Rewards earned prior to the date the program is discontinued will continue in force and may be used by the Certificate Holder's eligible students in accordance with SAGE's terms and conditions.

Certificate Holders may terminate participation in the College Tuition Rewards Program at any time by providing notice of intent to terminate to SAGE. Termination of participation status with SAGE does not affect eligibility for Covered Services under this Group Policy. To terminate participation in the College Tuition Rewards Program, send a notice by email to support@sagescholars.com or by regular mail to SAGE Scholars Inc., 1600 Arch Street, Suite 2502, Philadelphia, PA 19103.

General:
The terms and conditions related to the College Tuition Reward Program described by this Endorsement do not change the dental Plan's Group Policy and Certificate of Insurance, to which this Endorsement is attached. In the event of a conflict between the provisions in this Endorsement and the Certificate of Insurance or Group Policy, the Certificate of Insurance or Group Policy will control. Some states and/or jurisdictions may not permit use of this program for individuals under their jurisdiction.



Officer Signature