UNITED CONCORDIA

Insuring America's Dental Health

April 4, 2011

Group Administrator
Dickinson College
55 N West Street PO Box 1773
Attn Bernadette Pham
Carlisle, PA 17013

Dear Group Administrator:

Your group recently had a benefit change to its dental coverage with United Concordia effective July 1, 2010. Please destroy any old Certificates of Coverage/Insurance you may have on hand.

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

If you have questions about your dental benefit program, please contact your Sales/Service Representative. Other questions may be referred to United Concordia's website at www.unitedconcordia.com or to our Customer Service Department at 800-332-0366.

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

Sincerely,

Chad T. Cressler

Chad T Cressler
Director, Account Installation and Conversion Services

UNITED CONCORDIA

UNITED CONCORDIA

4401 Deer Path Road
Harrisburg, PA 17110

Dental Plan
Certificate of Insurance

Network Plan

Dickinson College
258730000, 258730099
July 1, 2010

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

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

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

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

Notice to Florida residents: The benefits of the policy providing your coverage are governed by a state other than Florida.

CERTIFICATE OF INSURANCE

INTRODUCTION

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

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

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

800-332-0366

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

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Appeal Procedure Addendum
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Schedule of Benefits
Schedule of Exclusions and Limitations

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during a specified period as shown on the Schedule of Benefits.

Maximum Allowable Charge - The maximum amount the Plan will allow for a specific Covered Service. Maximum Allowable Charges may vary depending upon the contract between the Company and the particular 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 costs of Members choosing Non-Participating Dentists.

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

Non-Participating Dentist - A dentist who has not signed a contract with the Company or an affiliate of the Company.

Participating Dentist - A dentist who has executed a Participating Dentist Agreement with the Company or an affiliate of the Company, under which he/she agrees to accept the Company's Maximum Allowable Charges as payment in full for Covered Services.

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 that the Policyholder must remit to the Company in exchange for coverage of the Policyholder's Members.

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

Schedule of Benefits - Attached summary of Covered Services, Plan payment percentages, 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.

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

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

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

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

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

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

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

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

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

Enrollment Changes

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

- birth of a child;
- adoption of a child;
- court order of placement or custody of a child;
- change in student status for a child;
- marriage of the Certificate Holder;
- domestic partnership of the Certificate Holder,

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

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

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

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

For an enrolled Dependent child who is mentally or physically handicapped, evidence of his/her reliance on You for maintenance and support due to his/her condition must also be supplied to Us within 30 days after said Dependent attains the limiting age shown in the definition of Dependent. If the Dependent is a full-time student at an accredited educational institution, the evidence must be provided within 30 days after the Dependent attains the limiting age for students. Such evidence will be requested based on information provided by the Member's physician but no more frequently than annually.

Dependent coverage may only be terminated when certain life change events occur. These events include:

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

Late Enrollment

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

Voluntary Disenrollment

If You chose to drop Your coverage or Your Dependents' coverage under the Plan at any time during the contract year other than at open enrollment, You will not be permitted to enroll Yourself or Your Dependents at a later time unless You supply proof of loss of coverage under another dental plan or You or Your Dependents are eligible for a special enrollment period required by applicable state or federal law or permitted by Your Group under the rules of its benefit plans. The loss of coverage must be due to a valid life change event such as death, divorce or change in employment status of spouse. If You supply such proof, You will be permitted to re-enroll at the next open enrollment period. You will be considered a new enrollee with respect to application of any Waiting Periods or benefit level changes shown on the Schedule of Benefits.

HOW THE DENTAL PLAN WORKS

Choice of Provider

You may choose any licensed dentist for services. However, Your out-of-pocket costs will vary depending upon whether or not Your dentist participates with United Concordia. If You choose a Participating Dentist, You may limit Your out-of-pocket cost. Participating Dentists agree by contract to accept Maximum Allowable Charges as payment in full for Covered Services. Participating dentists also complete and send claims directly to Us for processing. To find a Participating Dentist, visit *Find a Dentist* on Our website at *www.unitedconcordia.com* or call Our Interactive Voice Response System at the toll-free number in the Introduction section of this Certificate.

If You go to a dentist who is not a United Concordia 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 result in higher out-of-pocket costs for You.

When You visit the dental office, let Your dentist know that You are covered under a United Concordia program and give the dental office Your contract ID number and group number. If Your dentist has questions about Your eligibility or benefits, instruct the office to call Our Interactive Voice Response System at the toll-free number in the Introduction section of this Certificate or visit *My Patients' Benefits* on Our website at *www.unitedconcordia.com*.

Claims Submission

Upon completion of treatment, the services performed must be reported to Us in order for You to receive benefits. This is done through submission of a paper claim or electronically. Participating Dentists will report services to Us directly for You and Your Dependents.

Most dental offices submit claims or report services for patients. However, if You do not receive treatment from a Participating Dentist, You may have to complete and send claims to Us in the event the dental office will not do this for You. To obtain a claim form, visit the Members link on our website at *www.unitedconcordia.com*. Be sure to include on the claim:

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

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

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

Should You have any questions concerning Your coverage, eligibility or a specific claim, contact Us at the address and telephone number in the Introduction section of this Certificate or log onto *My Dental Benefits* at *www.unitedconcordia.com*.

Predetermination

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

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

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

BENEFITS

Schedule of Benefits

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

- the classes and groupings of dental services covered, shown with a "Plan Pays" percentage greater than "0%".
- the percentage of the Maximum Allowable Charges the Plan will pay.
- any Waiting Periods that must be satisfied for particular services before the Plan will pay benefits. Waiting Periods are measured from date of enrollment in the Plan.
- any Deductibles You and/or Your family must pay before any benefits for Covered Services will be paid by the Plan, and the Covered Services for which there is no deductible. The Deductible is applied only to expenses for Covered Services and on either a calendar year or contract year basis (yearly period beginning with the Effective Date of the Group Policy).
- any Maximums for Covered Services for a given period of time; for example, annual for most services and lifetime for orthodontics. Annual Maximums are applied on either a calendar or contract year basis.

Your Out-of-Pocket Costs

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

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

Services

The general descriptions below explain the services on the Schedule of Benefits. The descriptions are not all-inclusive – they include only the most common dental procedures in a class or service grouping. Specific dental procedures may be shifted among groupings or classes or may not be covered depending on Your Group's choice of Plan. Check the Schedule of Benefits attached to this Certificate to see which groupings are covered ("Plan Pays percentage greater than "0%"). Also, have Your provider call Us to verify coverage of specific dental procedures or log on to *My Dental Benefits* or *My Patients' Benefits* at *www.unitedconcordia.com* to check coverage. Services covered on the Schedule of Benefits are also subject to Exclusions and Limitations. Be sure to review the Schedule of Exclusions and Limitations also attached to this Certificate.

- Exams and X-rays for diagnosis – oral evaluations, bitewings, periapical and full-mouth x-rays
- Cleanings, Fluoride Treatments, Sealants for prevention
- Palliative Treatment for relief of pain for dental emergencies
- Space Maintainers to prevent tooth movement
- Basic Restorative to treat caries (cavities, tooth decay) – amalgam and anterior composite resin fillings, stainless steel crowns, crown build-ups and posts and cores.
- Endodontics to treat the dental pulp, pulp chamber and root canal – root canal treatment and retreatment, pulpotomy, pulpal therapy, apicoectomy, and apexification
- Non-surgical Periodontics for non-surgical treatment of diseases of the gums and bones supporting the teeth – periodontal scaling and root planing, periodontal maintenance
- Repairs of Crowns, Inlays, Onlays, Bridges, Dentures – repair, recementation, re-lining, re-basing and adjustment
- Simple Extractions – non-surgical removal of teeth and roots
- Surgical Periodontics for surgical treatment of the tissues supporting and surrounding the teeth (gums and bone) – gingivectomy, gingivoplasty, gingival curretage, osseous surgery, crown lengthening, bone and tissue replacement grafts
- Complex Oral Surgery for surgical treatment of the hard and soft tissues of the mouth – surgical extractions, impactions, excisions, exposure, root removal; alveoplasty and vestibuloplasty

- Anesthesia for elimination of pain during treatment – general or nitrous oxide or IV sedation
- Inlays, Onlays, Crowns when the teeth cannot be restored by fillings
- Prosthetics – fixed bridges, partial and complete dentures
- Orthodontics for treatment of poor alignment and occlusion – diagnostic x-rays, active treatment and retention for eligible dependent children

Exclusions and Limitations

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

Payment of Benefits

If You have treatment performed by a Participating Dentist, We will pay covered benefits directly to the Participating Dentist. Both You and the dentist will be notified of benefits covered, Plan payment and any amounts You owe for Coinsurance, Deductibles, charges exceeding Maximums or charges for services not covered. Payment will be based on the Maximum Allowable Charge the treating Participating Dentist has contracted to accept.

If You receive treatment from a Non-Participating Dentist, We will send payment for covered benefits to You. You will be notified of the services covered, Plan payment and any amounts You owe for Coinsurance, Deductibles, charges exceeding Maximums or charges for services not covered. The Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the dentist any difference between the Plan's payment and the dentist's full charge for the services.

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, from the person to whom it was paid, or from the dentist to whom the payment was made on behalf of the Member. We will recover the overpayment either by requesting a refund or offsetting the amount overpaid from future claim payments. Recovery will be done in accordance with any applicable state laws or regulations.

Coordination of Benefits (COB)

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

1. The following words and phrases regarding the Coordination of Benefits ("COB") provision are defined as set forth below:

   A) **Allowable Amount** is the Plan's allowance for items of expense, when the care is covered at least in part by one or more Plans covering the Member for whom the claim is made.
   B) **Claim Determination Period** means a benefit year. However, it does not include any part of a year during which a person has no coverage under this Plan.

C) **Other Dental Plan** is any form of coverage which is separate from this Plan with which coordination is allowed. **Other Dental Plan** will be any of the following which provides dental benefits, or services, for the following: Group insurance or group type coverage, whether insured or uninsured. It also includes coverage other than school accident type coverage (including grammar, high school and college student coverages) for accidents only, including athletic injury, either on a twenty-four (24) hour basis or on a "to and from school basis," or group or group type hospital indemnity benefits of $100 per day or less.

D) **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.

E) **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.

F) **Plan** means this document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.

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

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

A) If the other plan does not have a provision similar to this one, then that plan will be primary.

B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.

C) Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:

1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

D) Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:

1) First, the plan of the parent with custody of the child.
2) Then, the plan of the spouse of the parent with the custody of the child; and
3) Finally, the plan of the parent not having custody of the child.
4) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
5) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 3-C) above, titled Dependent Child/Parents Not Separated or Divorced.

E) Active/Inactive Member

1) For actively employed Members and their spouses over the age of 65 who are covered by Medicare, the plan will be primary.
2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.

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

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

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

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

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

Workers' Compensation

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

Review of a Benefit Determination

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

TERMINATION -- WHEN COVERAGE ENDS

Your coverage and/or Your Dependents' coverage will end:

- on the date You lose eligibility under Your Group's eligibility requirements; or
- on the date Premium payment ceases for You and/or Your Dependents, as specified by your Group; or
- on the date Your Dependent(s) cease to meet the requirements in the definition of Dependent in the Definitions section of this Certificate;

If Your coverage or Your Dependents' coverage is terminated as described above, coverage for completion of a dental procedure requiring two or more visits on separate days will be extended for a period of 90 days after the Member's Termination Date in order for the procedure to be finished. The procedure must be started prior to the Member's Termination Date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Member's Termination Date.

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

In the event of a default in Premium payment by the Policyholder, coverage will remain in effect for the Grace Period extended for payment of the overdue Premium. If the Premium is not received by the end of the Grace Period, the Group Policy will be cancelled and coverage will terminate the first day following the end of the Grace Period.

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

CONTINUATION COVERAGE

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

GENERAL PROVISIONS

This Certificate includes and incorporates any and all riders, endorsements, addenda, and schedules and together with the Group Policy represents the entire agreement between the parties with respect to the subject matter. The failure of any section or subsection of this Certificate shall not affect the validity, legality and enforceability of the remaining sections.

Except as otherwise herein provided, this Certificate may be amended, changed or modified only in writing 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 the state indicated on the State Law Provisions Addendum.

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

DEFINITIONS

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

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

"Authorized representative" is a person granted authority by You and the Company to act on Your behalf regarding a claim for benefit or an appeal of an adverse benefit determination. An assignment of benefits is not a grant of authority to act on Your behalf in pursuing and appealing a benefit determination.

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

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

PROCEDURE

You or Your authorized representative may file an appeal with Us within 180 days of receipt of an adverse benefit determination. To file an appeal, telephone the toll-free number listed in Your Certificate of Coverage 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 upon request and free of charge, reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts;
d) a statement of Your right to bring a civil action under ERISA; and
e) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

PENNSYLVANIA STATE LAW PROVISIONS ADDENDUM

TO

CERTIFICATE OF INSURANCE

This addendum is effective on the Effective Date as stated in the Certificate of Insurance "Certificate" and attached to and made part of the Certificate.

The following provision is substituted for the Dependents definition in the section entitled DEFINITIONS in this Certificate:

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

(a) until the end of the month which he/she reaches age 26; or
(b) until the end of the month which he/she reaches age 26 if he/she is a full-time student at an accredited educational institution and chiefly reliant upon the Certificate Holder for maintenance and support; or
(c) when an enrolled full-time student's education is interrupted by military service, until the end of the period beyond the above-stated student age limit, equal to the duration of the enrolled full-time student's service of 30 or more consecutive days on active duty for any reserve component of the United States armed forces or the Pennsylvania National Guard, including State duty or until said enrollee is no longer a full-time student, whichever is sooner;
(d) to any age if he/she is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

The following provision is added to the Enrollment Changes sub-section of the ELIGIBILITY AND ENROLLMENT section of this Certificate:

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

When an enrolled, full-time student's education is interrupted by military service as detailed in the Definition of Dependent of this Certificate, enrollment may be extended beyond the limiting age for full-time students. To qualify for the extension, the Member must submit the required Department of Military and Veterans Affairs (DMVA) forms to notify Us of placement on active duty, of completion of active duty and of re-enrollment as a full-time student for the first term or semester starting 60 or more days after release from active duty. The DMVA forms are available online at *www.dmva.state.pa.us*.

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

The following sub-sections are added to the section entitled HOW THE DENTAL PLAN WORKS in this Certificate:

Notice of Claim

Written notice of claim must be given to the Company within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Member to the Company, 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 15 days after the Company received notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

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

Proof of Loss

Written proof of loss must be furnished to the Company at its said office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 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 from receipt of due written proof of such loss. The Company may extend this 30-day period by no more than 15 days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Company. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid quarterly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims

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

Physical Examinations

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

Legal Actions

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

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

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

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

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

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.
>
> Maximum Allowable Charges for Covered Services are determined by geographical area of the dental office. The Maximum Allowable Charges in the geographical area of the dental office are used to calculate the Company's payment on claims. 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.

Schedule of Benefits
Concordia Select [sm]

Group Name: Dickinson College
Group Number: 258730000, 258730099 ***Effective Date: July 1, 2010***

	Plan Payment Percentages			
	Yr 1	***Yr 2***	***Yr 3***	***Yr 4 or More***
Class I Services				
Exams	80%	100%	100%	100%
All X-Rays	80%	100%	100%	100%
Cleanings & Fluoride	80%	100%	100%	100%
Sealants	80%	100%	100%	100%
Palliative Treatment (Emergency)	80%	100%	100%	100%
Space Maintainers	80%	100%	100%	100%
Class II Services				
Basic Restorative (Fillings, etc.)	50%	65%	80%	80%
Endodontics	50%	65%	80%	80%
Non-Surgical Periodontics	50%	65%	80%	80%
Simple Extractions	50%	65%	80%	80%
Complex Oral Surgery	50%	65%	80%	80%
General Anesthesia	50%	65%	80%	80%
Class III Services				
Repairs of Crowns, Inlays, Onlays	25%	40%	50%	50%
Repairs of Bridges	25%	40%	50%	50%
Denture Repair	25%	40%	50%	50%
Surgical Periodontics	25%	40%	50%	50%
Inlays, Onlays, Crowns	25%	40%	50%	50%
Prosthetics (Bridges, Dentures)	25%	40%	50%	50%
Orthodontics				
Diagnostic, Active, Retention Treatment	0%	0%	0%	0%
Deductibles & Maximums *Calendar Year Deductible per Member (excluding Class I Services) not to exceed the amount shown per family*	$50/ $150			
Calendar Year Maximum per Member	$1000			

Coverage Rules

Under this Plan, Your coverage begins at the above Year 1 level subject to any applicable credit for prior coverage provisions as detailed below and progressively increases as shown to the maximum level if you remain continuously enrolled. Advancement from level to level occurs on the yearly anniversary of Your initial enrollment. Your Dependents' coverage level will match Your coverage level throughout Your enrollment.

If You were enrolled under Your Group's prior fee-for-service dental program immediately preceding the initial Effective Date of this Plan, You will receive credit for this enrollment. Proof of such prior coverage must be submitted to and accepted by Us prior to the initial Effective Date of this Plan. If accepted, You will begin coverage under this Plan at the Year 3 level. If acceptable proof of prior dental coverage is not supplied to Us, this credit provision will not apply and Your coverage will begin at the Year 1 level. Certificate Holders who enroll after the initial Effective Date of this Plan will begin coverage at the Year 1 level.

If You choose to disenroll from this Plan and then later re-enroll, Your coverage will revert to the Year 1 level available at the time of re-enrollment regardless of Your coverage level during any preceding period of coverage under this Plan.

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.

Participating Dentists accept the Maximum Allowable Charge as payment in full.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

Exclusions and limitations may differ by state. Some exclusions and/or limitations may be waived depending on the Member's medical condition. Only American Dental Association procedure codes are covered.

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 (e.g. 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 (e.g. 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.

   For Group Policies issued and delivered in Georgia, Missouri and Virginia, only services that are the responsibility of Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

   For Group Policies issued and delivered in North Carolina, services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act are excluded only to the extent such services or supplies are the liability of the employee according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

   For Group Policies issued and delivered in Maryland, this exclusion does not apply.
4. For prescription and non-prescription drugs, vitamins or dietary supplements.

   For Group Policies issued and delivered in Arizona and New Mexico, this exclusion does not apply.
5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.

   For Group Policies issued and delivered in Washington, this exclusion does not apply when required dental services and procedures are performed in a dental office for covered persons under the age of seven (7) or physically or developmentally disabled.

   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.
6. Which are Cosmetic in nature as determined by the Company (e.g. bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

   For Group Policies issued and delivered in New Jersey, this exclusion does not apply for Cosmetic services for newly born children of Members.

   For Group Policies issued and delivered in Washington, this exclusion does not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.
7. Elective procedures (e.g. the prophylactic extraction of third molars).
8. 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).

   For Group Policies issued and delivered in Kentucky, Minnesota and Pennsylvania, this exclusion shall not apply to newly born children of Members including newly adoptive children, regardless of age.

   For Group Policies issued and delivered in Colorado, Hawaii, Indiana, Missouri, New Jersey and Virginia, this exclusion shall not apply to newly born children of Members.

   For Group Policies issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.

   For Group Policies issued and delivered in Washington, this exclusion shall not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.
9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the Certificate.

10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. 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.

    For Group Policies issued and delivered in New York, diagnostic services and treatment of jaw joint problems related to a medical condition are excluded unless specifically covered under the Certificate. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (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.

    For Group Policies issued and delivered in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for treatment of temporomandibular joint disorder (TMD) rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease or injury and such procedures are covered under the Certificate or the Schedule of Benefits.

    For Group Policies issued and delivered in Minnesota, this exclusion does not apply.

11. For treatment of fractures and dislocations of the jaw.

    For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

12. For treatment of malignancies or neoplasms.

13. Services and/or appliances that alter the vertical dimension (e.g. full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

15. Preventive restorations.

16. Periodontal splinting of teeth by any method.

17. For duplicate dentures, prosthetic devices or any other duplicative device.

18. For which in the absence of insurance the Member would incur no charge.

19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.

20. 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.

    For Group Policies issued and delivered in Oklahoma, this exclusion does not apply.

21. For treatment and appliances for bruxism (e.g. night grinding of teeth).

22. 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.

    For Group Policies issued and delivered in Maryland, failure to furnish the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the required time, if the claim is furnished as soon as reasonably possible, and, except in the absence of legal capacity of the Member, not later than one (1) year from the time the claim is otherwise required.

23. Incomplete treatment (e.g. patient does not return to complete treatment) and temporary services (e.g. temporary restorations).

24. Procedures that are:

    - part of a service but are reported as separate services
    - reported in a treatment sequence that is not appropriate
    - misreported or that represent a procedure other than the one reported.

25. Specialized procedures and techniques (e.g. precision attachments, copings and intentional root canal treatment).

26. Fees for broken appointments.

27. 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 12:01 a.m. of the birthday when the patient reaches any stated age:

1. Full mouth x-rays – one (1) every 5 year(s).
2. Bitewing x-rays – one (1) set(s) per 6 months under age fourteen (14) and one (1) set(s) per 12 months age fourteen (14) and older.
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 – one (1) 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. Prophylaxis – two (2) per 12 months. One (1) additional for Members under the care of a medical professional during pregnancy.
5. Fluoride treatment – two (2) per 12 months under age nineteen (19).
6. Space maintainers – one (1) per three (3) year period for Members under age nineteen (19) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.
7. Sealants – one (1) per tooth per 3 year(s) under age sixteen (16) on permanent first and second molars.
8. Prefabricated stainless steel crowns – one (1) per tooth per lifetime for Members under age fifteen (15).
9. Periodontal Services:
    - Full mouth debridement – one (1) per lifetime.
    - Periodontal maintenance following active periodontal therapy – two (2) per 12 months in addition to routine prophylaxis.
    - 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.
10. Replacement of restorative services only when they are not, and cannot be made, serviceable:
    - Basic restorations – not within 12 months of previous placement.
    - Single crowns, inlays, onlays – not within 5 year(s) of previous placement.
    - Buildups and post and cores – not within 5 year(s) of previous placement.
    - Replacement of natural tooth/teeth in an arch – not within 5 year(s) of a fixed partial denture, full denture or partial removable denture.
11. 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 3 year(s) thereafter.
12. Pulpal therapy – one (1) per eligible tooth per lifetime. Eligible teeth limited to primary anterior teeth under age six (6) and primary posterior molars under age twelve (12).
13. Root canal retreatment – one (1) per tooth per lifetime.
14. Recementation – one (1) per 12 months. Recementation during the first 12 months following insertion of the crown or bridge by the same dentist is included in the crown or bridge benefit.
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. Payment for orthodontic services shall cease at the end of the month after termination by the Company.

    This limitation does not apply to Group Policies issued and delivered in Maryland.

DAVIS VISION *Benefits You Can See*

1. DISCOUNT PROGRAM

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

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

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

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

Discount Schedule continued . . .

DAVIS VISION™
THE EYECARE ADVANTAGE

This card entitles the bearer and family to special discounted pricing

Name _____
Group United Concordia
Control Code 7602
Signature _____



Benefits you can see.

Discount Schedule continued . . .

Other Products

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

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

2. LENS 123®

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

3. LASER VISION CORRECTION

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

HOW THE DISCOUNT PROGRAM WORKS WITH YOUR PLAN

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

ACCESSING BENEFIT AND PROVIDER INFORMATION

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

AUTOMATED SERVICES (available 24/7)

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

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

CUSTOMER SERVICE

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

DAVIS VISION™
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UNITED CONCORDIA

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4401 Deer Path Road
Harrisburg, PA 17110

Dental Plan
Certificate of Insurance

Network Plan

Dickinson College
258730100, 258730199
July 1, 2010

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

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

In DE, DC, IL, KY, MD, MO, NC, NJ, PA, United Concordia is underwritten by
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In NY, United Concordia is underwritten by
United Concordia Insurance Company of New York

Notice to Florida residents: The benefits of the policy providing your coverage are governed by a state other than Florida.

CERTIFICATE OF INSURANCE

INTRODUCTION

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

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

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

800-332-0366

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during a specified period as shown on the Schedule of Benefits.

Maximum Allowable Charge - The maximum amount the Plan will allow for a specific Covered Service. Maximum Allowable Charges may vary depending upon the contract between the Company and the particular 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 costs of Members choosing Non-Participating Dentists.

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

Non-Participating Dentist - A dentist who has not signed a contract with the Company or an affiliate of the Company.

Participating Dentist - A dentist who has executed a Participating Dentist Agreement with the Company or an affiliate of the Company, under which he/she agrees to accept the Company's Maximum Allowable Charges as payment in full for Covered Services.

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 that the Policyholder must remit to the Company in exchange for coverage of the Policyholder's Members.

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

Schedule of Benefits - Attached summary of Covered Services, Plan payment percentages, 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.

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

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

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

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

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

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

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

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

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

Enrollment Changes

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

- birth of a child;
- adoption of a child;
- court order of placement or custody of a child;
- change in student status for a child;
- marriage of the Certificate Holder;
- domestic partnership of the Certificate Holder,

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

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

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

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

For an enrolled Dependent child who is mentally or physically handicapped, evidence of his/her reliance on You for maintenance and support due to his/her condition must also be supplied to Us within 30 days after said Dependent attains the limiting age shown in the definition of Dependent. If the Dependent is a full-time student at an accredited educational institution, the evidence must be provided within 30 days after the Dependent attains the limiting age for students. Such evidence will be requested based on information provided by the Member's physician but no more frequently than annually.

Dependent coverage may only be terminated when certain life change events occur. These events include:

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

Late Enrollment

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

Voluntary Disenrollment

If You chose to drop Your coverage or Your Dependents' coverage under the Plan at any time during the contract year other than at open enrollment, You will not be permitted to enroll Yourself or Your Dependents at a later time unless You supply proof of loss of coverage under another dental plan or You or Your Dependents are eligible for a special enrollment period required by applicable state or federal law or permitted by Your Group under the rules of its benefit plans. The loss of coverage must be due to a valid life change event such as death, divorce or change in employment status of spouse. If You supply such proof, You will be permitted to re-enroll at the next open enrollment period. You will be considered a new enrollee with respect to application of any Waiting Periods or benefit level changes shown on the Schedule of Benefits.

HOW THE DENTAL PLAN WORKS

Choice of Provider

You may choose any licensed dentist for services. However, Your out-of-pocket costs will vary depending upon whether or not Your dentist participates with United Concordia. If You choose a Participating Dentist, You may limit Your out-of-pocket cost. Participating Dentists agree by contract to accept Maximum Allowable Charges as payment in full for Covered Services. Participating dentists also complete and send claims directly to Us for processing. To find a Participating Dentist, visit *Find a Dentist* on Our website at *www.unitedconcordia.com* or call Our Interactive Voice Response System at the toll-free number in the Introduction section of this Certificate.

If You go to a dentist who is not a United Concordia 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 result in higher out-of-pocket costs for You.

When You visit the dental office, let Your dentist know that You are covered under a United Concordia program and give the dental office Your contract ID number and group number. If Your dentist has questions about Your eligibility or benefits, instruct the office to call Our Interactive Voice Response System at the toll-free number in the Introduction section of this Certificate or visit *My Patients' Benefits* on Our website at *www.unitedconcordia.com*.

Claims Submission

Upon completion of treatment, the services performed must be reported to Us in order for You to receive benefits. This is done through submission of a paper claim or electronically. Participating Dentists will report services to Us directly for You and Your Dependents.

Most dental offices submit claims or report services for patients. However, if You do not receive treatment from a Participating Dentist, You may have to complete and send claims to Us in the event the dental office will not do this for You. To obtain a claim form, visit the Members link on our website at *www.unitedconcordia.com*. Be sure to include on the claim:

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

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

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

Should You have any questions concerning Your coverage, eligibility or a specific claim, contact Us at the address and telephone number in the Introduction section of this Certificate or log onto *My Dental Benefits* at *www.unitedconcordia.com*.

Predetermination

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

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

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

BENEFITS

Schedule of Benefits

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

- the classes and groupings of dental services covered, shown with a "Plan Pays" percentage greater than "0%".
- the percentage of the Maximum Allowable Charges the Plan will pay.
- any Waiting Periods that must be satisfied for particular services before the Plan will pay benefits. Waiting Periods are measured from date of enrollment in the Plan.
- any Deductibles You and/or Your family must pay before any benefits for Covered Services will be paid by the Plan, and the Covered Services for which there is no deductible. The Deductible is applied only to expenses for Covered Services and on either a calendar year or contract year basis (yearly period beginning with the Effective Date of the Group Policy).
- any Maximums for Covered Services for a given period of time; for example, annual for most services and lifetime for orthodontics. Annual Maximums are applied on either a calendar or contract year basis.

Your Out-of-Pocket Costs

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

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

Services

The general descriptions below explain the services on the Schedule of Benefits. The descriptions are not all-inclusive – they include only the most common dental procedures in a class or service grouping. Specific dental procedures may be shifted among groupings or classes or may not be covered depending on Your Group's choice of Plan. Check the Schedule of Benefits attached to this Certificate to see which groupings are covered ("Plan Pays percentage greater than "0%"). Also, have Your provider call Us to verify coverage of specific dental procedures or log on to *My Dental Benefits* or *My Patients' Benefits* at www.unitedconcordia.com to check coverage. Services covered on the Schedule of Benefits are also subject to Exclusions and Limitations. Be sure to review the Schedule of Exclusions and Limitations also attached to this Certificate.

- Exams and X-rays for diagnosis – oral evaluations, bitewings, periapical and full-mouth x-rays
- Cleanings, Fluoride Treatments, Sealants for prevention
- Palliative Treatment for relief of pain for dental emergencies
- Space Maintainers to prevent tooth movement
- Basic Restorative to treat caries (cavities, tooth decay) – amalgam and anterior composite resin fillings, stainless steel crowns, crown build-ups and posts and cores.
- Endodontics to treat the dental pulp, pulp chamber and root canal – root canal treatment and retreatment, pulpotomy, pulpal therapy, apicoectomy, and apexification
- Non-surgical Periodontics for non-surgical treatment of diseases of the gums and bones supporting the teeth – periodontal scaling and root planing, periodontal maintenance
- Repairs of Crowns, Inlays, Onlays, Bridges, Dentures – repair, recementation, re-lining, re-basing and adjustment
- Simple Extractions – non-surgical removal of teeth and roots
- Surgical Periodontics for surgical treatment of the tissues supporting and surrounding the teeth (gums and bone) – gingivectomy, gingivoplasty, gingival curretage, osseous surgery, crown lengthening, bone and tissue replacement grafts
- Complex Oral Surgery for surgical treatment of the hard and soft tissues of the mouth – surgical extractions, impactions, excisions, exposure, root removal; alveoplasty and vestibuloplasty

- Anesthesia for elimination of pain during treatment – general or nitrous oxide or IV sedation
- Inlays, Onlays, Crowns when the teeth cannot be restored by fillings
- Prosthetics – fixed bridges, partial and complete dentures
- Orthodontics for treatment of poor alignment and occlusion – diagnostic x-rays, active treatment and retention for eligible dependent children

Exclusions and Limitations

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

Payment of Benefits

If You have treatment performed by a Participating Dentist, We will pay covered benefits directly to the Participating Dentist. Both You and the dentist will be notified of benefits covered, Plan payment and any amounts You owe for Coinsurance, Deductibles, charges exceeding Maximums or charges for services not covered. Payment will be based on the Maximum Allowable Charge the treating Participating Dentist has contracted to accept.

If You receive treatment from a Non-Participating Dentist, We will send payment for covered benefits to You. You will be notified of the services covered, Plan payment and any amounts You owe for Coinsurance, Deductibles, charges exceeding Maximums or charges for services not covered. The Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the dentist any difference between the Plan's payment and the dentist's full charge for the services.

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, from the person to whom it was paid, or from the dentist to whom the payment was made on behalf of the Member. We will recover the overpayment either by requesting a refund or offsetting the amount overpaid from future claim payments. Recovery will be done in accordance with any applicable state laws or regulations.

Coordination of Benefits (COB)

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

1. The following words and phrases regarding the Coordination of Benefits ("COB") provision are defined as set forth below:

   A) **Allowable Amount** is the Plan's allowance for items of expense, when the care is covered at least in part by one or more Plans covering the Member for whom the claim is made.
   B) **Claim Determination Period** means a benefit year. However, it does not include any part of a year during which a person has no coverage under this Plan.

C) **Other Dental Plan** is any form of coverage which is separate from this Plan with which coordination is allowed. **Other Dental Plan** will be any of the following which provides dental benefits, or services, for the following: Group insurance or group type coverage, whether insured or uninsured. It also includes coverage other than school accident type coverage (including grammar, high school and college student coverages) for accidents only, including athletic injury, either on a twenty-four (24) hour basis or on a "to and from school basis," or group or group type hospital indemnity benefits of $100 per day or less.

D) **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.

E) **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.

F) **Plan** means this document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.

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

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

A) If the other plan does not have a provision similar to this one, then that plan will be primary.

B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.

C) Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:

1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

D) Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:

1) First, the plan of the parent with custody of the child.
2) Then, the plan of the spouse of the parent with the custody of the child; and
3) Finally, the plan of the parent not having custody of the child.
4) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
5) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 3-C) above, titled Dependent Child/Parents Not Separated or Divorced.

E) Active/Inactive Member

1) For actively employed Members and their spouses over the age of 65 who are covered by Medicare, the plan will be primary.
2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.

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

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

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

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

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

Workers' Compensation

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

Review of a Benefit Determination

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

TERMINATION -- WHEN COVERAGE ENDS

Your coverage and/or Your Dependents' coverage will end:

- on the date You lose eligibility under Your Group's eligibility requirements; or
- on the date Premium payment ceases for You and/or Your Dependents, as specified by your Group; or
- on the date Your Dependent(s) cease to meet the requirements in the definition of Dependent in the Definitions section of this Certificate;

If Your coverage or Your Dependents' coverage is terminated as described above, coverage for completion of a dental procedure requiring two or more visits on separate days will be extended for a period of 90 days after the Member's Termination Date in order for the procedure to be finished. The procedure must be started prior to the Member's Termination Date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Member's Termination Date.

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

In the event of a default in Premium payment by the Policyholder, coverage will remain in effect for the Grace Period extended for payment of the overdue Premium. If the Premium is not received by the end of the Grace Period, the Group Policy will be cancelled and coverage will terminate the first day following the end of the Grace Period.

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

CONTINUATION COVERAGE

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

GENERAL PROVISIONS

This Certificate includes and incorporates any and all riders, endorsements, addenda, and schedules and together with the Group Policy represents the entire agreement between the parties with respect to the subject matter. The failure of any section or subsection of this Certificate shall not affect the validity, legality and enforceability of the remaining sections.

Except as otherwise herein provided, this Certificate may be amended, changed or modified only in writing 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 the state indicated on the State Law Provisions Addendum.

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

DEFINITIONS

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

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

"Authorized representative" is a person granted authority by You and the Company to act on Your behalf regarding a claim for benefit or an appeal of an adverse benefit determination. An assignment of benefits is not a grant of authority to act on Your behalf in pursuing and appealing a benefit determination.

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

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

PROCEDURE

You or Your authorized representative may file an appeal with Us within 180 days of receipt of an adverse benefit determination. To file an appeal, telephone the toll-free number listed in Your Certificate of Coverage 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 upon request and free of charge, reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts;
d) a statement of Your right to bring a civil action under ERISA; and
e) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

PENNSYLVANIA STATE LAW PROVISIONS ADDENDUM

TO

CERTIFICATE OF INSURANCE

This addendum is effective on the Effective Date as stated in the Certificate of Insurance "Certificate" and attached to and made part of the Certificate.

The following provision is substituted for the Dependents definition in the section entitled DEFINITIONS in this Certificate:

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

(a) until the end of the month which he/she reaches age 26; or
(b) until the end of the month which he/she reaches age 26 if he/she is a full-time student at an accredited educational institution and chiefly reliant upon the Certificate Holder for maintenance and support; or
(c) when an enrolled full-time student's education is interrupted by military service, until the end of the period beyond the above-stated student age limit, equal to the duration of the enrolled full-time student's service of 30 or more consecutive days on active duty for any reserve component of the United States armed forces or the Pennsylvania National Guard, including State duty or until said enrollee is no longer a full-time student, whichever is sooner;
(d) to any age if he/she is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

The following provision is added to the Enrollment Changes sub-section of the ELIGIBILITY AND ENROLLMENT section of this Certificate:

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

When an enrolled, full-time student's education is interrupted by military service as detailed in the Definition of Dependent of this Certificate, enrollment may be extended beyond the limiting age for full-time students. To qualify for the extension, the Member must submit the required Department of Military and Veterans Affairs (DMVA) forms to notify Us of placement on active duty, of completion of active duty and of re-enrollment as a full-time student for the first term or semester starting 60 or more days after release from active duty. The DMVA forms are available online at *www.dmva.state.pa.us*.

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

The following sub-sections are added to the section entitled HOW THE DENTAL PLAN WORKS in this Certificate:

Notice of Claim

Written notice of claim must be given to the Company within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Member to the Company, 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 15 days after the Company received notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

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

Proof of Loss

Written proof of loss must be furnished to the Company at its said office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 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 from receipt of due written proof of such loss. The Company may extend this 30-day period by no more than 15 days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Company. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid quarterly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims

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

Physical Examinations

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

Legal Actions

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

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

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

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

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

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. 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 determined as a 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 updated periodically.

Schedule of Benefits

Concordia Choice

Group Name: Dickinson College
Group Number:* 258730100, 258730199** ***Effective Date: July 1, 2010

	Plan Pays
Class I Services	
• Exams	**100%**
• All X-Rays	**100%**
• Cleanings & Fluoride Treatments	**100%**
• Sealants	**100%**
• Palliative Treatment (Emergency)	**100%**
Class II Services	
• Space Maintainers	**80%**
• Basic Restorative (Fillings, etc.)	**80%**
• Endodontics	**80%**
• Non-Surgical Periodontics	**80%**
• Repairs of Crowns, Inlays, Onlays	**80%**
• Repairs of Bridges	**80%**
• Denture Repair	**80%**
• Simple Extractions	**80%**
• Surgical Periodontics	**80%**
• Complex Oral Surgery	**80%**
• General Anesthesia	**80%**
Class III Services (after a six (6) month waiting period)	
• Inlays, Onlays, Crowns	**50%**
• Prosthetics (Bridges, Dentures)	**50%**
Orthodontics (after a twelve (12) month waiting period)	
• Diagnostic, Active, Retention Treatment	**50%**
• Limited to Dependent children under the age of 19	

Deductibles & Maximums

- *$75 per Calendar Year Deductible per Member (excluding Class I Services and Orthodontics) not to exceed $225 per family*
- *$1500 per Calendar Year Maximum per Member*
- *$1000 Lifetime Maximum per Member for Orthodontics*

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.

Participating Dentists accept the Maximum Allowable Charge as payment in full.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

Exclusions and limitations may differ by state. Some exclusions and/or limitations may be waived depending on the Member's medical condition. Only American Dental Association procedure codes are covered.

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 (e.g. 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 (e.g. 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.

   For Group Policies issued and delivered in Georgia, Missouri and Virginia, only services that are the responsibility of Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

   For Group Policies issued and delivered in North Carolina, services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act are excluded only to the extent such services or supplies are the liability of the employee according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

   For Group Policies issued and delivered in Maryland, this exclusion does not apply.
4. For prescription and non-prescription drugs, vitamins or dietary supplements.

   For Group Policies issued and delivered in Arizona and New Mexico, this exclusion does not apply.
5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.

   For Group Policies issued and delivered in Washington, this exclusion does not apply when required dental services and procedures are performed in a dental office for covered persons under the age of seven (7) or physically or developmentally disabled.

   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.
6. Which are Cosmetic in nature as determined by the Company (e.g. bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

   For Group Policies issued and delivered in New Jersey, this exclusion does not apply for Cosmetic services for newly born children of Members.

   For Group Policies issued and delivered in Washington, this exclusion does not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.
7. Elective procedures (e.g. the prophylactic extraction of third molars).
8. 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).

   For Group Policies issued and delivered in Kentucky, Minnesota and Pennsylvania, this exclusion shall not apply to newly born children of Members including newly adoptive children, regardless of age.

   For Group Policies issued and delivered in Colorado, Hawaii, Indiana, Missouri, New Jersey and Virginia, this exclusion shall not apply to newly born children of Members.

   For Group Policies issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.

   For Group Policies issued and delivered in Washington, this exclusion shall not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.
9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the Certificate.

10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. 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.

    For Group Policies issued and delivered in New York, diagnostic services and treatment of jaw joint problems related to a medical condition are excluded unless specifically covered under the Certificate. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (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.

    For Group Policies issued and delivered in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for treatment of temporomandibular joint disorder (TMD) rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease or injury and such procedures are covered under the Certificate or the Schedule of Benefits.

    For Group Policies issued and delivered in Minnesota, this exclusion does not apply.

11. For treatment of fractures and dislocations of the jaw.

    For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

12. For treatment of malignancies or neoplasms.

13. Services and/or appliances that alter the vertical dimension (e.g. full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

15. Preventive restorations.

16. Periodontal splinting of teeth by any method.

17. For duplicate dentures, prosthetic devices or any other duplicative device.

18. For which in the absence of insurance the Member would incur no charge.

19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.

20. 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.

    For Group Policies issued and delivered in Oklahoma, this exclusion does not apply.

21. For treatment and appliances for bruxism (e.g. night grinding of teeth).

22. 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.

    For Group Policies issued and delivered in Maryland, failure to furnish the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the required time, if the claim is furnished as soon as reasonably possible, and, except in the absence of legal capacity of the Member, not later than one (1) year from the time the claim is otherwise required.

23. Incomplete treatment (e.g. patient does not return to complete treatment) and temporary services (e.g. temporary restorations).

24. Procedures that are:

    - part of a service but are reported as separate services
    - reported in a treatment sequence that is not appropriate
    - misreported or that represent a procedure other than the one reported.

25. Specialized procedures and techniques (e.g. precision attachments, copings and intentional root canal treatment).

26. Fees for broken appointments.

27. 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 12:01 a.m. of the birthday when the patient reaches any stated age:

1. Full mouth x-rays – one (1) every 5 year(s).
2. Bitewing x-rays – one (1) set(s) per 6 months under age fourteen (14) and one (1) set(s) per 12 months age fourteen (14) and older.
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 – one (1) 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. Prophylaxis – two (2) per 12 months. One (1) additional for Members under the care of a medical professional during pregnancy.
5. Fluoride treatment – two (2) per 12 months under age nineteen (19).
6. Space maintainers – one (1) per three (3) year period for Members under age nineteen (19) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.
7. Sealants – one (1) per tooth per 3 year(s) under age sixteen (16) on permanent first and second molars.
8. Prefabricated stainless steel crowns – one (1) per tooth per lifetime for Members under age fifteen (15).
9. Periodontal Services:
    - Full mouth debridement – one (1) per lifetime.
    - Periodontal maintenance following active periodontal therapy – two (2) per 12 months in addition to routine prophylaxis.
    - 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.
10. Replacement of restorative services only when they are not, and cannot be made, serviceable:
    - Basic restorations – not within 12 months of previous placement.
    - Single crowns, inlays, onlays – not within 5 year(s) of previous placement.
    - Buildups and post and cores – not within 5 year(s) of previous placement.
    - Replacement of natural tooth/teeth in an arch – not within 5 year(s) of a fixed partial denture, full denture or partial removable denture.
11. 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 3 year(s) thereafter.
12. Pulpal therapy – one (1) per eligible tooth per lifetime. Eligible teeth limited to primary anterior teeth under age six (6) and primary posterior molars under age twelve (12).
13. Root canal retreatment – one (1) per tooth per lifetime.
14. Recementation – one (1) per 12 months. Recementation during the first 12 months following insertion of the crown or bridge by the same dentist is included in the crown or bridge benefit.
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. Payment for orthodontic services shall cease at the end of the month after termination by the Company.

    This limitation does not apply to Group Policies issued and delivered in Maryland.

DAVIS VISION *Benefits You Can See*

1. DISCOUNT PROGRAM

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

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

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

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

Discount Schedule continued . . .

DAVIS VISION™
THE EYECARE ADVANTAGE

This card entitles the bearer and family to special discounted pricing

Name _____
Group United Concordia
Control Code 7602
Signature _____

Benefits you can see.

Discount Schedule continued . . .

Other Products

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

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

2. LENS 123®

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

3. LASER VISION CORRECTION

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

HOW THE DISCOUNT PROGRAM WORKS WITH YOUR PLAN

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

ACCESSING BENEFIT AND PROVIDER INFORMATION

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

AUTOMATED SERVICES (available 24/7)

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

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

CUSTOMER SERVICE

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

DAVIS VISION™
THE EYECARE ADVANTAGE

CUSTOMER SERVICE
1-877-923-2847

UNITED CONCORDIA
Insuring America's Dental Health

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