UNITED CONCORDIA® DENTAL

Dental Benefits Summary for
L.A. DEPARTMENT OF WATER AND POWER-RETIREES

Network: Concordia Alliance

Benefit Category[1]	CONCORDIA PREFERRED PLAN	
	In-Network[2]	Non-Network[2]
Class I – Diagnostic/Preventive Services (Excluded from Annual Program Maximum)		
Exams	100%	100%
Bitewing X-rays		
All Other X-rays		
Cleanings & Fluoride Treatments (includes 1 additional cleaning during pregnancy)		
Sealants		
Palliative Treatment		
Class II – Basic Services		
Basic Restorative (Fillings)	80%	80%
Simple Extractions		
Space Maintainers		
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures		
Endodontics		
Nonsurgical Periodontics		
Surgical Periodontics		
Complex Oral Surgery		
General Anesthesia		
Class III – Major Services		
Inlays, Onlays, Crowns	70%	50%
Prosthetics (Bridges, Dentures)		
Maximums & Deductibles (cumulative of network and non-network)		
Annual Program Deductible (per person/per family)	$25/$75 Excludes Class I	$25/$75 Excludes Class I
Annual Program Maximum (per person)	$1,500 Excludes Class I	$1,500 Excludes Class I
Reimbursement	**Alliance**	**National Fee For Service**

Representative listing of covered services – certificate of coverage provides a detailed description of benefits.

1. Eligible dependent children to age 26.
2. Reimbursement is based on our schedule of maximum allowable charges (MACs). Network dentists agree to accept our allowances as payment in full for covered services. Non-network dentists may bill the member for any difference between our allowance and their fee. United Concordia Dental's standard exclusions and limitations apply.

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CA SCHEDULE OF EXCLUSIONS AND LIMITATIONS

THIS PLAN DOES NOT MEET THE MINIMUM ESSENTIAL HEALTH BENEFIT REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE FEDERAL AFFORDABLE CARE ACT.

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

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (for example but not limited to, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).

2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).

3. For Group Policies in California, the only services that are the responsibility of Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

4. For prescription and non-prescription drugs, vitamins or dietary supplements.

5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.

6. Which are solely Cosmetic in nature (for example but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

7. Elective procedures (for example but not limited to, the prophylactic extraction of third molars).

8. For congenital mouth malformations or skeletal imbalances (for example but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).

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 Schedule of Benefits or a Rider.

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.

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

12. For treatment of malignancies or neoplasms.

13. Services and/or appliances that alter the vertical dimension (for example but not limited to, 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.

21. For treatment and appliances for bruxism (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.

23. Incomplete treatment (for example but not limited to, patient does not return to complete treatment) and temporary services (for example but not limited to, temporary restorations).

24. Procedures that are:

    - part of a service but are reported as separate services; or
    - misreported or that represent a procedure other than the one reported.

25. Specialized procedures and techniques (for example but not limited to, precision attachments, copings and intentional root canal treatment).

26. Fees for broken appointments.

27. Those specifically listed on the Schedule of Benefits as "Not Covered" or "Plan Pays 0%".

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 fourteen (14).

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 of any basic restoration.
    - Single crowns, inlays, onlays – not within 5 year(s) of previous placement of any of the procedures in this category.

- Buildups and post and cores – not within 5 year(s) of previous placement placement of any of the procedures in this category.
- 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 only when there is no permanent tooth to replace it. 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 any preventive, restorative or prosthodontic service by the same dentist is included in the preventive, restorative or prosthodontic service benefit.

15. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a 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.

17. Intraoral Films:
    - Occlusal – two (2) per 24 months under age 8.

18. General anesthesia and IV sedation: a total of sixty 60 minutes per session.

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Rider to Schedule of Benefits

Preventive Incentive®

This Rider is effective on January 1, 2015 and is attached to and made a part of the Schedule of Benefits.

Benefits for the following services shown as covered on the Schedule of Benefits will not be counted toward accumulation of the program Maximum indicated on the Schedule of Benefits:

- Exams
- Bitewings X-Ray
- All Other X-Rays
- Cleanings Treatments
- Fluoride Treatments
- Sealants
- Palliative Treatment (Emergency)