

UNITED CONCORDIA INSURANCE COMPANY

4401 Deer Path Road
Harrisburg, PA 17110

**Dental Plan
Certificate of Insurance
Underwritten by United Concordia Insurance Company**

**LOS ANGELES UNIFIED SCHOOL DISTRICT
919914000
JANUARY 1, 2017**

This coverage does not include essential pediatric dental health benefits under the Federal Affordable Care Act.

For a listing of Participating Dentists, please call (844) 397-4176 or visit our online directory at www.ucci.com

This Plan utilizes a network of Participating (network) Dentists. The service area for the Plan is the State of California. If You or Your Dependents travel outside the service area or live away from the Certificate Holder's primary residence, Coinsurance for Covered Services received from both Participating and non-Participating Dentists will be the same as if provided in the service area. Out-of-Pocket Expenses, including Coinsurance and Deductibles, may be greater if You receive services from a non-Participating Provider.

If you are unable to access medically appropriate care within the network, We will arrange for the care to be provided by a non-Participating Dentist. Your costs will be the same as if care was provided by a Participating Dentist. If Your Plan has separate In-Network and Out-of-Network Maximums and Deductibles, any applicable Out-of-Pocket Expenses will be applied to the In-Network Deductible and/or Out-of-Pocket Expenses.

Complaints related to an inability to access needed healthcare in a timely manner can be submitted to Us at 844-397- 4176. If You are not satisfied with the resolution provided by Us, contact the California Department of Insurance at:

**California Department of Insurance
300 Capitol Mall, Suite 1700
Sacramento, CA 95814
(213) 897-8921
(800) 927-4357
TDD: (800) 482-4833
www.insurance.ca.gov**

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 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:

(844) 397-4176

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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Attached:

- Schedule of Benefits
- Schedule of Exclusions and Limitations

DEFINITIONS

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

Annual Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during a calendar year or Contract Year as shown on the Schedule of Benefits.

Certificate Holder(s) - An individual who, because of his/her status with the Policyholder, has enrolled him/herself and/or his/her eligible Dependents for dental coverage and for whom Premiums are paid. In the case of a Group Policy that covers only dependent children, the Certificate Holder must be the child's or children's parent, stepparent, legal guardian, or legal custodian,

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

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

Company - United Concordia, the insurer.

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

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

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

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

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

Dental Emergency – An acute condition which occurs suddenly, usually includes pain, swelling or bleeding and demands immediate professional dental services.

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.

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

Dependent(s) - Certificate Holder's spouse or domestic partner, as defined by Section 297 of the California Family Code, and any unmarried natural child, stepchild or adopted child of a Certificate Holder or child placed with the Certificate Holder or the Certificate Holder's Spouse or domestic partner by order of a court or administrative agency, enrolled in the Plan until the end of the month which he/she reaches twenty-six (26).

Certificate Holder's child, stepchild, or adopted child of a Certificate Holder or child placed with the Certificate Holder or the Certificate Holder's Spouse or domestic partner by order of a court or administrative agency to any age if he/she is and continues to be both chiefly incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition 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.

Elective Procedures – Procedures the patient elects to have even in the absence of any pathology or disease, excluding recognized diagnostic or preventative procedures.

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 based upon the advice of the general dental community including, but not limited to dental consultants, dental journals and/or governmental regulations, to make this determination.

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

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

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

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

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

Maximum Allowable Charge - The maximum amount the Plan will allow for a specific Covered Service.

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

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

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

Out-of-Pocket Maximum – The limit on the Deductibles and Coinsurance for Covered Services provided by Participating Dentists that the Certificate Holder is required to pay in a calendar year or Contract Year, as shown on the Schedule of Benefits. After this limit is reached, Covered Services from Participating Dentists are paid 100% by Us for the remainder of the calendar year or Contract Year unless subject to the Schedule of Exclusions and Limitations.

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

Services. Participating Dentists may also agree to limit their charges for any other services delivered to Members.

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

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

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

Prescription Drugs – Any drug prescribed by a dentist by way of a prescription, whether obtained from the dentist or dispensed by a pharmacy, including any non-prescription drugs, vitamins or dietary supplements.

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

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

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

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

Specialized Procedures and Techniques – Procedures that are not part of the routine fabrication of a standard prosthetic service.

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

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

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

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

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

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

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

Coverage for Members enrolling after the Group Policy Effective Date will begin on the date specified in the enrollment information supplied to Us provided Premium is paid.

The Company is not liable to pay benefits for any services started prior to a Member's Effective Date of coverage. Multi-visit procedures are considered "started" when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. Procedures started prior to the Member's Effective Date are the liability of the Member or a prior insurance carrier.

Enrollment Changes

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

- birth
- adoption
- court order of placement or custody
- marriage.

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 has a physically or mentally disabling injury, illness, or condition, evidence of his/her reliance on You for maintenance and support due to his/her condition must also be supplied to Us within 60 days of the date of receipt of the Company's notification that the dependent child's coverage will terminate upon attainment of the limiting age unless the Member submits proof of a physically or mentally disabling injury, illness, or condition. The Company will send notification to the Member at least 90 days prior to the date the dependent child attains the limiting age. 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 including death, divorce or reaching the limiting age or during open enrollment periods.

Late Enrollment

If You or Your Dependents are not enrolled within thirty-one (31) days of initial eligibility or during the Special Enrollment Period specified for a life change event, You or Your Dependents cannot enroll until the next Special Enrollment Period or open enrollment period conducted for Your Group unless otherwise permitted by applicable law or regulation intended to implement the federal Affordable Care Act, or specified in any applicable Late Entrant Rider to the Certificate of Insurance. If You are required by court order to provide coverage for a Dependent child, You will be permitted to enroll the Dependent child without regard to enrollment season restrictions.

HOW THE DENTAL PLAN WORKS

Choice of Provider

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

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

Your Group has purchased a Plan that requires You to choose a Participating Dentist in order to receive benefits. The only time You may receive a benefit for Covered Services performed by a Non-Participating Dentist is in the event of a Dental Emergency. Participating Dentists agree by contract to accept Maximum Allowable Charges as payment in full for Covered Services. Also, if agreed by the provider, Participating Dentists limit their charges for all services delivered to Members, even if the service is not covered for any reason and a benefit is not paid under this Plan. Participating Dentists also complete and send claims directly to Us for processing. To find a Participating Dentist, visit Our website at {www.unitedconcordia.com} or call Us at the toll-free number in the Introduction section of this Certificate or on Your ID card.

Time Limit on Certain Defenses

After two years from the date of issue of this Certificate, no misstatements, except fraudulent misstatements, made by the applicant in the application for this certificate shall be used to void the policy or to deny a claim for loss incurred commencing after the expiration of such two-year period.

Claim Forms

The standard practice of the Company, and the majority of its providers, is to use the American Dental Associations (ADA) standardized claim form. The Company will accept all other types of dental claim forms. However, at the request of the Member, the Company will furnish to the Member forms as are usually furnished by it for filing proof of loss.

Proof of Loss

Written proof of loss must be furnished to 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 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 one year from the time proof is otherwise required.

Time of Payment of Claims

All benefits payable under this Certificate for any loss other than loss for which this Certificate 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 Certificate 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.

Legal Actions

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

BENEFITS

Covered Services

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

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

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.

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 unless You indicate on the claim that You wish payment to be sent directly to Your treating dentist. 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 or from the person or Dentist to whom it was paid. We will recover the overpayment either by requesting a refund or offsetting the amount overpaid from future claim payments. This recovery will follow any applicable state laws or regulations. The Member must provide any assistance necessary, including furnishing information and signing necessary documents, for the Company to be reimbursed.

Coordination of Benefits (COB)

If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, benefits will be coordinated. This means that one plan will be the Primary Dental Benefit Plan and determine its benefits before those of the other plan and without considering the other plan's benefits. The other plan will be the Secondary Dental Benefit Plan and determine its benefits after the Primary Dental Benefit Plan. The Secondary Dental Benefit plan's benefits may be reduced because of the Primary Dental Benefit Plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses. 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 Dental Benefit Plan** is the plan which provides primary dental coverage and determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.
 - E) **Secondary Dental Benefit Plan** is the plan which provides secondary dental coverage and determines its benefits after those of the other plan (Primary Dental Benefit Plan). Benefits may be reduced because of the other plan's (Primary Dental Benefit Plan) benefits.
 - F) **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.
 - A) As the Primary Dental Benefit Plan, the Company will pay the maximum amount required by Your Group Policy when coordinating its benefits with a Secondary Dental Benefit Plan.
 - B) As the Secondary Dental Benefit Plan, the Company will pay the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the Member's total out-of-pocket cost payable under the Primary Dental Benefit Plan for benefits covered under the Secondary Dental Benefit Plan.

3. In order to determine which plan is primary, this Plan will use the following rules.
 - A) If the other 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 Dental Benefit 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.

Review of a Benefit Determination

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

Your Out-of-Pocket Costs

IMPORTANT: If You opt to receive dental services that are not Covered Services under this Plan, a Participating Dentist may charge You his or her usual and customary rate for those services. Prior to providing a Member with dental services that are not a Covered Service, the dentist should provide to the Member a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about dental coverage options, You may call our Customer Service Department at 1-800-332-0366 or Your insurance broker. To fully understand Your coverage, You may wish to carefully review this Certificate.

TERMINATION -- WHEN COVERAGE ENDS

A Member's coverage will end:

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

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

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

Benefits After Coverage Terminates

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

through the end of the month of the Member's Termination Date. This extension does not apply if the Group Policy terminates for failure to pay Premium.

CONTINUATION COVERAGE

Federal 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

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.

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.

APPEAL PROCEDURE

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

DEFINITIONS

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

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

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

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

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

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

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

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

PROCEDURE FOR PRE-SERVICE CLAIM

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

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

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

California Department of Insurance
300 Capitol Mall, Suite 1700
Sacramento, CA 95814
(213) 897-8921
(800) 927-4357
TDD: (800) 482-4833
www.insurance.ca.gov

PROCEDURE FOR POST-SERVICE CLAIM

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

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

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

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

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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.

FEDERAL LAW SUPPLEMENT

TO

CERTIFICATE OF INSURANCE

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

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

- (1) You or your dependent either loses eligibility for coverage under Medicaid or the Children's Health Insurance Program ("CHIP"); or
- (2) You or your dependent becomes eligible for premium assistance from Medicaid or CHIP allowing enrollment in a benefit program.

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

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

United Concordia Insurance Company

Schedule of Benefits

Concordia PreferredSM

Group Name: Los Angeles Unified School District

Group Number(s): 919914000

Effective Date: January 1, 2017

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

Service Category	Waiting Period	Plan Pays In-Network	Plan Pays Out-of-Network	Deductible Application In-Network	Deductible Application Out-of-Network
Diagnostic Services					
Pre-diagnostic and unspecified services	<i>None</i>	<i>100</i>	<i>80</i>	<i>no</i>	<i>no</i>
Tests and Examinations	<i>None</i>	<i>100</i>	<i>80</i>	<i>no</i>	<i>no</i>
Oral Evaluations (Exams)	<i>None</i>	<i>100</i>	<i>80</i>	<i>no</i>	<i>no</i>
Radiographs (X-Rays)					
Bitewings	<i>None</i>	<i>100</i>	<i>80</i>	<i>no</i>	<i>no</i>
Full mouth	<i>None</i>	<i>100</i>	<i>80</i>	<i>no</i>	<i>no</i>
Occlusal Films	<i>None</i>	<i>100</i>	<i>80</i>	<i>no</i>	<i>no</i>
Preventive Services					
Prophylaxis (Cleanings)	<i>None</i>	<i>100</i>	<i>80</i>	<i>no</i>	<i>no</i>
Fluoride Varnish	<i>None</i>	<i>100</i>	<i>80</i>	<i>no</i>	<i>no</i>
Topical fluoride	<i>None</i>	<i>100</i>	<i>80</i>	<i>no</i>	<i>no</i>
Sealants	<i>None</i>	<i>100</i>	<i>80</i>	<i>no</i>	<i>no</i>
Space Maintainers	<i>None</i>	<i>80</i>	<i>60</i>	<i>yes</i>	<i>yes</i>
Restorative Services					
Amalgam Restorations	<i>None</i>	<i>80</i>	<i>60</i>	<i>yes</i>	<i>yes</i>
Resin Based Composite –Anterior (White Fillings)	<i>None</i>	<i>80</i>	<i>60</i>	<i>yes</i>	<i>yes</i>

Service Category	Waiting Period	Plan Pays In-Network	Plan Pays Out-of-Network	Deductible Application In-Network	Deductible Application Out-of-Network
Single Crowns	None	50	50	yes	yes
Stainless Steel Crowns	None	80	60	yes	yes
Crown Repair	None	80	60	yes	yes
Endodontic Services					
Endodontic Therapy (Root canals, etc.)	None	80	60	yes	yes
Root Canal	None	80	60	yes	yes
Apicoectomy/Periradicular (Root Surgery)	None	80	60	yes	yes
Periodontal					
Surgical Periodontics	None	80	60	yes	yes
Non-Surgical Periodontics	None	80	60	yes	yes
Periodontal Maintenance	None	80	60	yes	yes
Prosthodontic Services					
Removable Complete and Partial Dentures	None	50	50	yes	yes
Fixed Partial Dentures (Bridges)	None	50	50	yes	yes
Adjustments and Repairs of Complete and Partial Dentures	None	50	50	yes	yes
Removal of Teeth					
Simple Extractions	None	80	60	yes	yes
Oral Surgery	None	80	60	yes	yes
Adjunctive General Services					
Consultations	None	80	60	yes	yes
General Anesthesia and IV Sedation	None	80	60	yes	yes
Palliative Treatment (Emergency)	None	80	60	yes	yes
Occlusal Guard (appliance only)	None	50	50	yes	yes
Orthodontic Services					
Orthodontic Services	None	50	50	no	no

Preventive Incentive:

When obtained from an in-network dentist, 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**
- **Cleanings (routine prophylaxis)**
- **All X-Rays**
- **Fluoride Treatments**
- **Palliative Treatment (Emergency)**
- **Space Maintainers**

Deductibles & Maximums In-Network and Out-of-Network

- *\$100 per calendar year Deductible per Member*
- *\$2000 per calendar year Maximum per Member*
- *\$750 lifetime Maximum per Member for Orthodontics*

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 prescription and non-prescription drugs, vitamins or dietary supplements not including injections of therapeutic drugs.
3. Administration of nitrous oxide and/or IV sedation, unless necessary in accordance with generally accepted dental standards.
4. Which are solely Cosmetic in nature (for example but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).
5. Elective procedures (for example but not limited to, the prophylactic extraction of third molars).
6. 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).
7. 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.
8. 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.
9. 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.
10. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
11. Restoration of a tooth structure damaged by attrition, abrasion or erosion, unless caused by disease.
12. Periodontal splinting of teeth by any method.
13. For duplicate dentures or prosthetic devices.
14. For which in the absence of insurance the Member would incur no charge.
15. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
16. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
17. 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 or provisional).
18. Procedures that are:
 - part of a service but are reported as separate services;
 - misreported or that represent a procedure other than the one reported;
 - covered under occupational disease law; or,
 - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.
19. Specialized procedures and techniques (for example but not limited to, precision attachments, copings and intentional root canal treatment).
20. Fees for broken appointments.
21. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or considered by generally accepted standards of care to be experimental in nature.
22. services covered under other coverage provided by the Policyholder.

23. biopsies of hard or soft oral tissue.
24. temporary or provisional restorations.
25. services for which the submitted documentation indicates a poor prognosis. "Poor prognosis" determination is based on generally accepted standards of care for treating the particular dental condition.
26. the following, when charged by the Dentist on a separate basis:
 - claim form completion;
 - infection control, such as gloves, masks, and sterilization of supplies; or
 - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide.
27. caries susceptibility tests.
28. cone beam imaging.
29. labial veneers.
30. modification of removable prosthodontic and other removable prosthetic services.
31. implants including, but not limited to any related surgery, placement, restorations, maintenance, and removal.
32. repair of implants.
33. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics.
34. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
35. intra and extraoral photographic images.

LIMITATIONS – Covered services are limited as detailed below.

1. Full mouth x-rays one (1) every three (3) calendar years.
2. Bitewing x-rays – two (2) sets per calendar year.
3. Oral exams and problem focused exams are no more than twice in a year.
4. Prophylaxis – two (2) per calendar year.
5. Fluoride treatment – one (1) per calendar year under age nineteen (19).
6. Space maintainers – one (1) per tooth per lifetime for Members under age fifteen (15) 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 every three (3) year(s) under age fourteen (14) 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 calendar year less the number of prophylaxis received during the year.
 - Periodontal scaling and root planing – one (1) per 24 months per area of the mouth.
 - Surgical periodontal procedures – one (1) 36 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 24 months of previous placement of any basic restoration.
 - Single crowns, inlays, onlays – not within 3 year(s) of previous placement of any of the procedures in this category.
 - Buildups and post and cores – not within 3 year(s) of previous placement of any of the procedures in this category.
 - Replacement of natural tooth/teeth in an arch – not within 3 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. Pulp therapy – one (1) per tooth per lifetime only when there is no permanent tooth to replace it. Eligible teeth limited to primary anterior teeth.
13. Root canal retreatment – one (1) per tooth per 24 months.
14. Recementation – one (1) per 3 calendar years. Recementation during the first 12 months following insertion any preventive, restorative or prosthodontic service by the same dentist is included in the preventive, restorative or prosthodontic service benefit.
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, if covered, shall cease at the end of the month after termination by the Company.
17. General anesthesia and IV sedation: a total of 60 minutes per session.
18. Occlusal guards: one (1) every three (3) years.