United Concordia Insurance Company

Schedule of Benefits

Concordia Preferred [sm]

Group Name: LAUNDRY AND DRY CLEANING WORKERS TF
Group Number(s): 740181004 Effective Date: July 1, 2025

The grid below provides information related to Covered Services under this Plan. If a service is a Covered Service, a percentage greater than zero in the column titled “Plan Pays 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. This Plan includes an alternate benefit provision as defined in the Certificate of Insurance. The alternate benefit provision applies to services denoted below with an asterisk “*".

Service Category	Waiting Period	Plan Pays In-Network	Plan Pays Out-of-Network	Deductible Application In-Network	Deductible Application Out-of-Network
Diagnostic Services					
Oral Evaluations (Exams)	***None***	***100%***	***50%***	***No***	***No***
Radiographs (X-Rays)					
Bitewings	***None***	***100%***	***50%***	***No***	***No***
Full mouth	***None***	***90%***	***50%***	***Yes***	***Yes***
Preventive Services					
Prophylaxis (Cleanings)	***None***	***100%***	***50%***	***No***	***No***
Fluoride	***None***	***100%***	***50%***	***No***	***No***
Sealants	***None***	***90%***	***50%***	***Yes***	***Yes***
Space Maintainers	***None***	***90%***	***50%***	***Yes***	***Yes***
Restorative Services					
Restorations	***None***	***90%***	***50%***	***Yes***	***Yes***
Single Crowns	***None***	***60%***	***50%***	***Yes***	***Yes***
Stainless Steel Crowns*	***None***	***90%***	***50%***	***Yes***	***Yes***
Inlays*	***None***	***60%***	***50%***	***Yes***	***Yes***
Onlays*	***None***	***60%***	***50%***	***Yes***	***Yes***
Inlay Repairs	***None***	***90%***	***50%***	***Yes***	***Yes***
Onlay Repairs	***None***	***90%***	***50%***	***Yes***	***Yes***
Crown Repair	***None***	***90%***	***50%***	***Yes***	***Yes***
Endodontic Services					

Service Category	Waiting Period	Plan Pays In-Network	Plan Pays Out-of-Network	Deductible Application In-Network	Deductible Application Out-of-Network
Endodontic Therapy (Root canals, etc.)	***None***	***60%***	***50%***	***Yes***	***Yes***
Root Canal Retreatment	***None***	***60%***	***50%***	***Yes***	***Yes***
Apicoectomy/Periradicular (Root Surgery)	***None***	***60%***	***50%***	***Yes***	***Yes***
Periodontal Services					
Surgical Periodontics	***None***	***60%***	***50%***	***Yes***	***Yes***
Non-Surgical Periodontics	***None***	***60%***	***50%***	***Yes***	***Yes***
Periodontal Maintenance	***None***	***60%***	***50%***	***Yes***	***Yes***
Prosthodontic Services					
Removable Complete and Partial Dentures	***None***	***60%***	***50%***	***Yes***	***Yes***
Adjustments of Complete and Partial Dentures	***None***	***90%***	***50%***	***Yes***	***Yes***
Repairs of Complete and Partial Dentures	***None***	***90%***	***50%***	***Yes***	***Yes***
Removal of Teeth					
Simple Extractions	***None***	***90%***	***50%***	***Yes***	***Yes***
Surgical Removal	***None***	***60%***	***50%***	***Yes***	***Yes***
Adjunctive General Services					
Consultations	***None***	***100%***	***50%***	***No***	***No***
General Anesthesia, Nitrous Oxide and/or IV Sedation	***None***	***60%***	***50%***	***Yes***	***Yes***
Palliative Treatment (Emergency)	***None***	***100%***	***50%***	***No***	***No***
Orthodontic Services					
Cosmetic Orthodontic Services	***None***	***0%***	***0%***	***N/A***	***N/A***

Deductibles & Maximums

- *$25 per contract year Deductible per Member not to exceed $75 per family*
- *$1,500 per contract year Maximum per Member*

UNITED CONCORDIA INSURANCE COMPANY

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

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

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (for example but not 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, services that are paid by 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, whitening, personalization of crowns).
7. Elective procedures.
8. Procedures performed when poor prognosis is indicated.
9. Those procedures considered experimental and investigational based on current standards of dental treatment.
10. Those performed for the comfort and convenience of the Member or provider.
11. For congenital mouth malformations or skeletal imbalances (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).
12. For dental implants services unless specifically covered under the Schedule of Benefits or a Rider.
13. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate in the Schedule of Benefits or a Rider. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
14. For treatment of fractures and dislocations of the jaw.
15. For treatment of malignancies or neoplasms.
16. Services and/or appliances that alter the vertical dimension (for example but not limited, full-mouth rehabilitation or reconstruction, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
17. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
18. Preventive restorations.
19. Periodontal splinting of teeth by any method.
20. For duplicate dentures, prosthetic devices or any other duplicative device.
21. For which in the absence of insurance the Member would incur no charge.
22. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
23. 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.
24. For treatment and appliances for bruxism (night grinding of teeth).
25. 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.
26. 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).
27. Procedures that are part of a service but are reported as separate services.
28. Procedures that are reported in a treatment sequence that is not appropriate or categorized as "misreported".
29. Procedures that are misreported or that represent a procedure other than the one reported.

30. Specialized procedures and techniques (for example but not limited to, laser assisted new attachment procedure; laser assisted peri-implantitis procedure; laser decontamination).
31. Fees for broken appointments.
32. Those specifically listed on the Schedule of Benefits as “Not Covered” or “Plan Pays 0%”.
33. Orthodontic services, supplies, and appliances.

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 six (6) months under age fourteen (14) and one (1) set(s) per twelve (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 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 primary 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 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 provided by the dentist. We will never interfere with care decisions between You and your dentist and prior authorizations of treatment are not required for any services. The ABP is applied to the claim after services have been provided. You may be responsbile for additional out-of-pocket costs if a less costly treatment option was available.

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