

**Benefit Summary
Individual 400 Dental Plan**

Annual Deductible Per Insured Person (Applies to Class II and III)	\$50 Per Contract Year
Annual Maximum Per Insured Person	\$2,000 Per Contract Year
Policy Pays	
Class I/ Diagnostic and Preventive Services (No Waiting Period)	
<ul style="list-style-type: none"> • Exams • All X-Rays • Cleanings • Fluoride Treatments • Sealants • Palliative Treatment (Emergency) 	100%
Class II/ Basic Services (No Waiting Period)	
<ul style="list-style-type: none"> • Space Maintainers • Periodontal Maintenance • Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures and Dentures 	80%
<ul style="list-style-type: none"> • Basic Restorative (Fillings, etc.) • Endodontics (Root canals, etc.) • Simple Extractions 	50%
Class III/ Major Services (After a twelve (12) month Waiting Period)	
<ul style="list-style-type: none"> • Complex Oral Surgery • General Anesthesia and/or Nitrous Oxide and/or IV Sedation • Nonsurgical Periodontics • Surgical Periodontics • Crowns, Inlays, Onlays • Prosthetics (Fixed Partial Dentures, Dentures) • Implants 	50%

The percentage in the Policy Pays column is the percentage of the policy's maximum allowable charge that the policy will pay for covered services provided by either a participating dentist or a nonparticipating dentist. Participating dentists accept the maximum allowable charge as payment in full. Nonparticipating dentists may bill you for the difference between their charge and the maximum allowable charge paid by the policy.

Dependent children are eligible to age 26 in all states unless otherwise specified.

All services listed on this benefit summary are subject to the attached exclusions and limitations and policy renewal and termination provisions. Waiting periods as shown on this Benefit Summary and other terms may apply.

Discounts may be available for non-covered services and services exceeding the annual maximum. Discounted services are not insurance. Payment is the member's responsibility. Discounted services are only available from those specific participating dentists who have agreed to accept United Concordia's allowances for all services rendered, whether covered or not. Discounts vary by dentist, service and geographic area.

This summary provides a very brief description of the important features of our dental insurance policy. This document is not the insurance policy; in the event of conflict, the policy will control. The insurance policy sets forth in detail the rights and obligations of both you and us as the insurance carrier underwriting the policy.

Important Regulatory Information

United Concordia individual dental insurance policies are underwritten by one of the following licensed subsidiaries of United Concordia Companies, Inc. (UCCI), which subsidiaries have sole financial responsibility for these policies.

- United Concordia Insurance Company when issued in *AZ, CA, FL, TX and WV*. Benefits are offered under policy number *IN01-0309UCIC* in *AZ, CA, and WV*, under *FLIN01-0309* in *FL* and under *TXIN01-0309* in *TX*.
- United Concordia Life and Health Insurance Company when issued in *PA*. Benefits are offered under policy number *PAIN01-0309* in *PA*.

The amount of benefits and cost depend upon the individual dental product selected. United Concordia policies cover dental benefits only. Policies are only available in the states listed above, and are not available in any U.S. territories or other countries.

The policyholder may return any United Concordia Policy for a full refund of premium, within ten days of its delivery if, after examination, the Policyholder is not satisfied for any reason. United Concordia policies renew from year to year as long as premium is paid timely unless United Concordia elects not to renew with 60 days advance notice in only the following situations: fraud or material misrepresentation by or with the knowledge of the policyholder or an insured dependent; except in PA, the policyholder or an insured dependent engages in intentional and abusive noncompliance with material provisions of the policy; or United Concordia ceases to renew all policies issued in a given state. The dental plan chosen, billing frequency, age, and place of residence are factors used in determining premium rates. Any change in premium will be made at renewal with at least 60 days advance notice. The policyholder may elect not to renew or to terminate the policy, in which case the policyholder may not apply for new dental insurance for self or dependents for three (3) years from the policy termination date. United Concordia may terminate the policy for non-payment of premium during the grace period granted for payment in accordance with the terms of the policy.

United Concordia Insurance Company is not licensed in AL, DE, DC, IL, KY, MD, MO, NJ, NY, NC and PA. United Concordia Insurance Company, California certificate of authority number 3739-0, is domiciled in Arizona at its statutory address, 2198 East Camelback Road, Suite 260, Phoenix, AZ 85016. The administrative office of UCCI and its licensed subsidiaries is located at 4401 Deer Path Road, Harrisburg, PA 17110.

Why Do I Need Dental Insurance?

Dental insurance provides you and your family with coverage for the known expenses—cleanings, exams and x-rays—as well as the potential unknown ones, such as fillings crowns and oral surgery.

Makes sense, right? But some people think they can't afford dental insurance—or that they can pay for their preventive care and just hope for the best. Maybe skip an exam or two to save money. How harmful can that be?

Well, research increasingly suggests that there are links between a person's oral and overall health. In fact, poor oral care could result in periodontal disease, which has been linked to a variety of medical conditions including:

- Heart disease
- Stroke
- Diabetes
- Respiratory disease

And, many studies have show that pregnant women with periodontal disease are at a greater risk for having low-birthweight and preterm babies.

At United Concordia, we care about both your oral and overall health. That's why we offer a range of individual dental policy options which provide you with the level of coverage you want at a price you can afford. We also negotiate *reduced fees* with our network dentists, which helps to lower your overall dental bill. If you choose to go without insurance, you may pay the full amount of the dentist's *regular fees* for all procedures, including routine care.

Why take the chance? For a relatively small investment in premiums, you can obtain the dental care you and your family need to help maintain good oral health. Please review the chart below for an example of how much you could save with a United Concordia dental plan.

MEMBER COST SAVINGS COMPARISON—PLAN IND400						
Individual Without Dental Insurance vs. United Concordia Dental Member						
Service	Average Dentist's Charge ² /Individual Without Dental Insurance Pays Full Amount	Individual with United Concordia Dental Plan ¹				Savings for United Concordia Member vs. Individual Without Dental Insurance ^{4, 5}
		United Concordia Plan Negotiated Fee ³	Coverage Level	United Concordia Pays ⁴	United Concordia Member Pays ⁴	
2 Cleanings	\$188	\$92	100%	\$92	\$0	\$188
2 Exams	\$122	\$48	100%	\$48	\$0	\$122
1 Set of X-Rays	\$44	\$26	100%	\$26	\$0	\$44
1 "White" Filling ⁶	\$150	\$78	50%	\$39	\$39	\$111
1 Crown	\$997	\$626	50%	\$313	\$313	\$684
	\$1,501	\$870	N/A	\$518	\$352	\$1,149

1. For illustrative purposes only. Assumes coverage levels of 100% for Class I; 80% or 50%, depending on the service, for Class II; and 50% for Class III services, and that the deductible (if applicable) has already been met.

2. Average dentist's charge based on internal 2009 data for zip codes 90001-93099; actual charges will vary by dentist, service and geographic region, 05/09.

3. The negotiated fee is the Maximum Allowable Charge (MAC) set by United Concordia as the highest amount to be paid to an Advantage Plus network dentist for a particular service.

4. Assumes services received by an Advantage Plus network dentist.

5. Actual savings will be reduced by premium costs.

6. White fillings are fully covered for front teeth only. White fillings on back teeth will be covered at the same MAC as silver (amalgam) fillings.

How United Concordia's Individual Dental Policy Works

Once you enroll in a United Concordia dental policy, you will receive an email providing you with a link to your insurance policy. **Please ensure that you read your policy carefully.** You will also receive ID cards in the mail for each member of your family. Once you receive this information, you will be ready to begin using your plan. When you visit your dentist, present your ID card at check-in. If you choose to visit one of our network dentists, he or she will file your claims for you. If you visit a non-network dentist, you may need to file your own claims.

Frequently Asked Questions

Your Dental Plan Details

Q. Are there waiting periods for certain dental services?

A. Certain services may have waiting periods. These vary by product. Please review the benefit summary and read the policy documents for more detailed information.

Finding a Dentist

Q. How do I find out if my dentist participates in the United Concordia Dental network?

A. Just use our [Find a Dentist](#) online search tool. In the "Select Your Dental Network" drop-down box, select **Concordia Advantage Plus**, then indicate your other search preferences. You can also call Customer Service toll-free at 1-866-568-6099 between 8 a.m. and 8 p.m. ET.

Q. If my dentist does not participate in United Concordia's network, can I nominate him/her for participation?

A. Yes. We realize that you may wish to continue seeing your current dentist. That's why we gladly accept nominations for new network dentists. To nominate your dentist go to [Member Information and Forms](#) and click on **Nominating Your Dentist**.

Q. What are the benefits of visiting a United Concordia network dentist?

A. Although your United Concordia dental plan allows you to use any licensed dentist, using a network dentist will benefit you in many ways including:

- **Saving money**—Because our network dentists accept our negotiated fees as payment in full for covered services, there's no balance billing. This means your out-of-pocket savings may be greater when you choose a dentist in our network. In addition, discounts may be available for non-covered services and services exceeding the annual maximum. Please note that discounted services are not insurance and payment is the member's responsibility. Discounted services are only available from those specific participating dentists who have agreed to accept United Concordia's allowances for all services rendered, whether covered or not. Discounts vary by dentist, service and geographic area.
- **Saving time**—Our network dentists agree to file your claims, so it's one less thing for you to do.
- **Providing peace of mind**—All of our network dentists undergo a rigorous review through our quality assurance process and routine verification of their credentials.
- **Giving you freedom of choice**—Each member of your family can choose to visit a different network or non-network dentist.

Q. If my dentist does not participate in United Concordia’s network, can I still see him/her?

A. Yes, you may receive care from any licensed dentist; however, the amount you are responsible to pay may be higher if you visit a non-network dentist. Also, if you visit a non-network dentist, you will not be eligible for possible discounts for non-covered services and services exceeding the annual maximum.

Q. Do I have to complete a claim form for each dental visit?

A. If you receive care from a United Concordia network dentist, you do not need to worry about claim forms—your dentist will take care of all the paperwork. However, if you receive care from a non-network dentist, you may have to complete and submit your own claims. Claim forms can be downloaded by clicking this link [Claim Forms](#).

Premiums and Billing

Q. For what amounts can a dentist bill me?

A. United Concordia network dentists accept our reimbursements, also known as maximum allowable charges (MACs), as payment in full for covered services. Network dentists can charge you for applicable deductibles and coinsurance amounts, but they cannot balance bill you for the difference between their standard charges and the MACs. Non-network dentists *can* balance bill you for the difference between their standard charges and the MACs.

Q. When will you raise my premium rates?

A. Your premium rates are guaranteed not to increase for a period of 12 months, as long as you stay within the same plan and do not change the type of coverage (from single to two-party, for example).

Q. What is the contract year deductible?

A. The contract year deductible is the amount of dental expense each member must pay for the dental policy to begin paying for benefits. Class I services, if covered by your dental product, are exempt from the deductible. The deductible amount varies by product. Please review the benefit summary and read the policy documents for more detailed information.

Q. What is the contract year maximum?

A. The contract year maximum is the dollar amount that the policy will pay toward the cost of dental care incurred by a member during a defined contract year. The annual maximum varies by product. Please review the benefit summary and read the policy documents for more detailed information.

If you have additional questions or concerns regarding the United Concordia dental plan, or would like clarification on your benefits, please call Customer Service at 1-866-568-6099 between 8 a.m. and 8 p.m. ET. Please note that questions about your dental treatment should first be discussed with your dentist.

Standard Exclusions and Limitations

Benefits are subject to exclusions and limitations that may differ by state. Consult your insurance policy for a full listing of exclusions and limitations.

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

1. Started prior to the Insured Person's Effective Date or after the Termination Date of coverage under the Policy (e.g. multi-visit procedures such as endodontics, crowns, fixed partial dentures, 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 Insured Person(s) is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.
4. For prescription and non-prescription drugs, vitamins or dietary supplements.
5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.
6. Which are Cosmetic in nature as determined by the Company (e.g. bleaching, veneer facings, personalization or characterization of crowns, fixed partial dentures and/or dentures).
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).
9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically indicated on the Schedule of Benefits.
10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Policy. 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 (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 Insured Person 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 (e.g. night grinding of teeth).
22. For any claims submitted to the Company by the Insured Person or on behalf of the Insured Person in excess of twelve (12) months after the date of service.
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 Insured Person 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 Insured Person 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 Insured Persons 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 fixed partial dentures by the same dentist is included in the crown or fixed partial dentures 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 Insured Person to the less costly treatment. However, if the Insured Person and the dentist choose the more expensive treatment, the Insured Person is responsible for the additional charges beyond those allowed under this ABP. This limitation does not apply to covered implantology services.
16. Implantology services are limited to one (1) per tooth per lifetime and to Insured Persons age eighteen (18) and older.