UNITED CONCORDIA® DENTAL

PPO Plans

Dental Programs for Pennsylvania Employer Groups with 2-50 Enrolled Contracts

Valid programs and rates for effective dates of July 1, 2015 through December 1, 2015.
Rates are guaranteed for 12 months from the effective date, provided the group meets underwriting guidelines.
The rates on this card do not apply to existing United Concordia Dental groups.

FFS PRODUCTS	Choice	Flex	Flex	Flex	Preferred	
UNITED CONCORDIA DENTAL PLAN OPTION						
Standard Plan Option	**C-V6**	**F-2W**	**F-3W**	**F-3Wo***	**P-10W**	
CLASS I SERVICES					Network	Non-Network
Exams, Cleanings & Fluoride Treatments	100%	100%	100%	100%	100%	80%
All X-Rays						
Sealants						
Palliative Treatment (Emergency)						
CLASS II SERVICES					Network	Non-Network
Space Maintainers	80%	80%	80%	80%	80%	60%
Basic Restorative (Fillings, etc.)						
Repairs (Crowns, Inlays, Onlays, Bridges, Dentures)						
Oral Surgery (including Extractions)						
General Anesthesia						
Endodontics						
Periodontics (Surgical and Nonsurgical)						
Posterior Resins (White Fillings)						
CLASS III SERVICES					Network	Non-Network
Inlays, Onlays, Crowns	50%	Not Covered	50%	50%	50%	50%
Prosthetics (Bridges, Dentures)						
ORTHODONTICS (dependent children to age 19)					Network	Non-Network
Diagnostic, Active, Retention Treatment	Not Covered	Not Covered	Not Covered	50%	50%	50%
Waiting Periods						
Class I services	None	None	None	None	None	
Class II services	None	None	None	None	None	
Class III services	6 Months	Not Covered	None	None	None	
Orthodontic services	Not Covered	Not Covered	Not Covered	None	None	
DEDUCTIBLES & MAXIMUMS						
Calendar Year Deductible (Flex or Choice: waived for Class I services) (Preferred: waived for Orthodontic & In-Network Class I services)	$50/$150	$50/$150	$50/$150	$50/$150	$50/$150	
Orthodontics (Lifetime Maximum)	Not Covered	Not Covered	Not Covered	$1,000	$1,000	
Network						
Network Reimbursement	Advantage	Advantage	Advantage	Advantage	Advantage	
Out-of Network Reimbursement	Advantage	Advantage	Advantage	Advantage		Advantage

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FFSTemp07012012

United Concordia Dental PPO Plans

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Central

Valid in the following Zip Codes: 168xx, 170xx-176xx, 178xx-181xx, 195xx-196xx

Minimum Enrollment & Participation	Groups 2-9			Groups 10-50				
Minimum Enrolled	2	2	2	10	10	10	10[a]	10
Minimum Participation	100%	100%	100%	20%	70%	70%	70%	70%
STANDARD PLAN OPTION	**F-2W**	**F-3W**	**P-10W**	**C-V6**	**F-2W**	**F-3W**	**F-3Wo***	**P-10W**
$1,000 Calendar Year Maximum								
Plan ID	**HV45Q8**	**LP59B9**	**OP9784**	**LLWLL2**	**I2JH21**	**05ST3P**	**PW0RJT**	**TK5ZZG**
Two-Tier Employee	$21.50	$31.30	$29.80	$32.40	$19.70	$28.70	$28.70	$27.30
Family	$52.90	$77.10	$89.30	$79.80	$48.60	$70.80	$82.80	$79.10
Four-Tier Employee	$21.50	$31.30	$29.80	$32.40	$19.70	$28.70	$28.70	$27.30
Employee & 1 Adult	$41.10	$60.00	$57.10	$62.10	$37.70	$55.10	$55.10	$52.20
Employee & Child(ren)	$37.50	$54.70	$67.70	$56.60	$34.50	$50.20	$62.00	$59.40
Family	$62.40	$91.30	$102.50	$94.40	$57.30	$83.70	$95.60	$91.20
$1,500 Calendar Year Maximum								
Plan ID	**PO18A2**	**ZO19F9**	**OR1932**	**IWEVRG**	**5ZEHTR**	**QV5B7O**	**6YT8JY**	**G2BY8M**
Two-Tier Employee	$22.50	$32.80	$31.30	$33.90	$20.70	$30.10	$30.10	$28.60
Family	$55.40	$80.80	$93.00	$83.70	$50.90	$74.20	$86.20	$82.50
Four-Tier Employee	$22.50	$32.80	$31.30	$33.90	$20.70	$30.10	$30.10	$28.60
Employee & 1 Adult	$43.00	$62.90	$59.90	$65.10	$39.50	$57.70	$57.70	$54.80
Employee & Child(ren)	$39.30	$57.30	$70.30	$59.30	$36.10	$52.60	$64.40	$61.80
Family	$65.50	$95.70	$106.90	$99.00	$60.10	$87.80	$99.60	$95.20

Northeastern

Valid in the following Zip Codes: 169xx, 177xx, 182xx-188xx

Minimum Enrollment & Participation	Groups 2-9			Groups 10-50				
Minimum Enrolled	2	2	2	10	10	10	10[a]	10
Minimum Participation	100%	100%	100%	20%	70%	70%	70%	70%
STANDARD PLAN OPTION	**F-2W**	**F-3W**	**P-10W**	**C-V6**	**F-2W**	**F-3W**	**F-3Wo***	**P-10W**
$1,000 Calendar Year Maximum								
Plan ID	**HR13H6**	**OB59L8**	**J99406**	**6DW051**	**B1UOB8**	**REK2B4**	**320XRM**	**4R83EP**
Two-Tier Employee	$22.50	$32.80	$31.30	$34.00	$20.70	$30.10	$30.10	$28.70
Family	$57.10	$83.30	$95.40	$86.20	$52.40	$76.50	$88.50	$84.70
Four-Tier Employee	$22.50	$32.80	$31.30	$34.00	$20.70	$30.10	$30.10	$28.70
Employee & 1 Adult	$44.40	$64.90	$61.80	$67.10	$40.70	$59.50	$59.50	$56.60
Employee & Child(ren)	$40.50	$59.00	$72.00	$61.10	$37.20	$54.20	$66.00	$63.40
Family	$67.40	$98.60	$109.70	$102.00	$61.90	$90.50	$102.30	$97.80
$1,500 Calendar Year Maximum								
Plan ID	**AV0796**	**EN70O8**	**UL67G0**	**RE5XJ6**	**PMS0N7**	**6V2TII**	**FJFQCJ**	**79LBSY**
Two-Tier Employee	$23.60	$34.40	$32.90	$35.60	$21.70	$31.60	$31.60	$30.10
Family	$59.80	$87.30	$99.40	$90.40	$55.00	$80.20	$92.20	$88.30
Four-Tier Employee	$23.60	$34.40	$32.90	$35.60	$21.70	$31.60	$31.60	$30.10
Employee & 1 Adult	$46.50	$68.10	$64.90	$70.40	$42.70	$62.40	$62.40	$59.50
Employee & Child(ren)	$42.40	$61.90	$74.80	$64.00	$39.00	$56.80	$68.60	$65.90
Family	$70.70	$103.40	$114.50	$107.00	$64.90	$94.90	$106.70	$102.20

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For use with rate card FFSTemp072012

United Concordia Dental PPO Plans

Dental Programs for Pennsylvania Employer Groups with 2-50 Enrolled Contracts

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Southeastern

Valid in the following Zip Codes: 189xx-194xx

Minimum Enrollment & Participation	Groups 2-9			Groups 10-50				
Minimum Enrolled	2	2	2	10	10	10	10[a]	10
Minimum Participation	100%	100%	100%	20%	70%	70%	70%	70%
STANDARD PLAN OPTION	**F-2W**	**F-3W**	**P-10W**	**C-V6**	**F-2W**	**F-3W**	**F-3Wo[a]**	**P-10W**
$1,000 Calendar Year Maximum								
Plan ID	**OC70A4**	**N160P1**	**IO6845**	**37IZJT**	**KC1S9G**	**ISA0TJ**	**4TYA8H**	**ZX6UOV**
Two-Tier Employee	$19.70	$28.70	$27.20	$29.70	$18.10	$26.30	$26.30	$24.90
Family	$49.90	$72.70	$85.00	$75.20	$45.80	$66.70	$78.70	$75.20
Four-Tier Employee	$19.70	$28.70	$27.20	$29.70	$18.10	$26.30	$26.30	$24.90
Employee & 1 Adult	$38.60	$56.40	$53.50	$58.30	$35.40	$51.80	$51.80	$49.00
Employee & Child(ren)	$35.40	$51.50	$64.70	$53.30	$32.50	$47.30	$59.10	$56.60
Family	$59.00	$86.20	$97.60	$89.20	$54.20	$79.10	$91.00	$86.70
$1,500 Calendar Year Maximum								
Plan ID	**N58842**	**769878**	**FN58A7**	**HZKEIJ**	**UC52BU**	**GCP086**	**VMS6ZN**	**I2AINL**
Two-Tier Employee	$20.60	$30.10	$28.60	$31.10	$19.00	$27.60	$27.60	$26.20
Family	$52.20	$76.20	$88.40	$78.90	$48.00	$70.00	$82.00	$78.30
Four-Tier Employee	$20.60	$30.10	$28.60	$31.10	$19.00	$27.60	$27.60	$26.20
Employee & 1 Adult	$40.50	$59.10	$56.20	$61.20	$37.20	$54.30	$54.30	$51.40
Employee & Child(ren)	$37.00	$54.00	$67.10	$55.90	$34.00	$49.60	$61.40	$58.80
Family	$61.90	$90.40	$101.70	$93.50	$56.80	$83.00	$94.80	$90.50

Western

Valid in the following Zip Codes: 150xx -167xx

Minimum Enrollment & Participation	Groups 2-9			Groups 10-50				
Minimum Enrolled	2	2	2	10	10	10	10[a]	10
Minimum Participation	100%	100%	100%	20%	70%	70%	70%	70%
STANDARD PLAN OPTION	**F-2W**	**F-3W**	**P-10W**	**C-V6**	**F-2W**	**F-3W**	**F-3Wo[a]**	**P-10W**
$1,000 Calendar Year Maximum								
Plan ID	**IUZRKP**	**S166ER**	**BCCI0S**	**K6NRI3**	**7RDADM**	**5KQ84N**	**UA3TCZ**	**RQXB8V**
Two-Tier Employee	$18.80	$27.40	$26.00	$30.00	$18.30	$26.60	$26.60	$25.20
Family	$49.10	$71.60	$84.00	$78.50	$47.80	$69.60	$81.60	$78.00
Four-Tier Employee	$18.80	$27.40	$26.00	$30.00	$18.30	$26.60	$26.60	$25.20
Employee & 1 Adult	$37.00	$54.10	$51.20	$59.20	$36.00	$52.60	$52.60	$49.80
Employee & Child(ren)	$33.70	$49.00	$62.20	$53.70	$32.80	$47.70	$59.50	$57.00
Family	$56.10	$82.00	$93.40	$89.80	$54.60	$79.70	$91.50	$87.20
$1,500 Calendar Year Maximum								
Plan ID	**HP84V7**	**H78091**	**MK15U0**	**X3I2JL**	**66P1NI**	**BP42PQ**	**M8VAQK**	**S95U5S**
Two-Tier Employee	$19.70	$28.70	$27.20	$31.40	$19.20	$27.90	$27.90	$26.50
Family	$51.50	$75.10	$87.40	$82.30	$50.10	$73.00	$85.00	$81.30
Four-Tier Employee	$19.70	$28.70	$27.20	$31.40	$19.20	$27.90	$27.90	$26.50
Employee & 1 Adult	$38.80	$56.70	$53.80	$62.10	$37.70	$55.10	$55.10	$52.30
Employee & Child(ren)	$35.30	$51.40	$64.60	$56.30	$34.30	$50.00	$61.80	$59.20
Family	$58.80	$86.00	$97.30	$94.20	$57.20	$83.50	$95.40	$91.00

[a] In order for a group with 10-24 enrolled contracts to qualify for dependent orthodontic coverage, the group must provide proof of prior fee-for-service orthodontic coverage.

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UNITED CONCORDIA® DENTAL

Underwriting Guidelines

The following underwriting guidelines apply to the program on the attached document.

1. In network benefits are calculated using United Concordia's Maximum Allowable Charge (MAC). Out-of-network benefits are calculated based upon United Concordia's MAC.
2. Both minimum enrolled contract count and participation requirement must be achieved.
3. Spousal waive out count toward participation requirements but are not applicable to the minimum enrollment requirements.
4. Programs assume dependent children are eligible to age 26 and full-time students to age 26.
5. Class I, II, and III services count toward the maximum.
6. Standard United Concordia policies and procedures and exclusions and limitations apply (refer to Es & Ls included).
7. If the group is multi-state, at least 90% of those eligible are located in the rate card region.
8. This chart is a representative listing of services covered under the proposed program.
9. The overall average number of members per contract is less than 5.
10. Dental plan is not offered in conjunction with another dental plan or another carrier.
11. The group has no claims experience available.
12. Rates on this card apply only to new business sold through United Concordia.
13. All proposed rates, guarantees and caps assume no change to the proposed benefit design. United Concordia reserves the right to re-evaluate proposed rates and benefit if any state or federally mandated benefits or fees are imposed.

United Concordia reserves the right to replace this rate card at any time. Please contact your sales representative to ensure that you have the most update information.

United Concordia will not accept business submitted by or pay commissions to producers who are not appointed. Any premium payment or group application submitted to United Concordia or its sales personnel by non-appointed producers must be accompanied by completed appointment paperwork or it will be returned to the non-appointed producer. A producer's quotation of rates to groups or submission of business to United Concordia constitutes acceptance of and agreement to comply with this rule. To obtain an appointment packet, visit the Producer section of www.unitedconcordia.com.

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 and limitations may differ by state as specified below. Only American Dental Association procedure codes are covered. In the event of a conflict between the Group Contract and this proposal, the Group Contract will govern.

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 limitation, 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. That are the responsibility of Workers' Compensation or employer's liability insurance policy. The Company's benefits would be excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

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

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

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

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

For Group Policies issued and delivered in Arizona and New Mexico, this exclusion does not apply.

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

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

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

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

6. Which are Cosmetic in nature as determined by the Company (for example but not limitation, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

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

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

For Group Policies issued and delivered in Washington, this exclusion does not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.

7. Elective procedures (for example but not limitation, the prophylactic extraction of third molars).
8. For congenital mouth malformations or skeletal imbalances (for example but not limitation, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).

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

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

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

For Group Policies issued and delivered in Washington, this exclusion shall not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.

9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the Certificate.
10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

For Group Policies issued and delivered in New York, diagnostic services and treatment of jaw joint problems related to a medical condition are excluded unless specifically covered under the Certificate. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

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

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

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

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

12. For treatment of malignancies or neoplasms.
13. Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
15. Preventive restorations
16. Periodontal splinting of teeth by any method.
17. For duplicate dentures, prosthetic devices or any other duplicative device.
18. For which in the absence of insurance the Member would incur no charge.
19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
20. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

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

21. For treatment and appliances for bruxism (night grinding of teeth).
22. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.

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

23. Incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).
24. Procedures that are:
- part of a service but are reported as separate services; or
- reported in a treatment sequence that is not appropriate; or
- misreported or that represent a procedure other than the one reported.

25. Specialized procedures and techniques (for example but not limitation, precision attachments, copings and intentional root canal treatment).
26. Fees for broken appointments.
27. Those specifically listed on the Schedule of Benefits as "Not Covered" or "Plan Pays 0%".
28. 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.
29. For prosthetic services (e.g. full or partial dentures or fixed bridges) if such services replace one (1) or more teeth missing prior to Member's eligibility under the Group Policy.

For Group Policies issued and delivered in Georgia and North Carolina, this exclusion does not apply.

For Group Policies issued and delivered in Maryland, this exclusion does not apply to prosthetic services placed five (5) years after the Member's Effective Date for services.

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 calendar year(s).
2. Bitewing x-rays – one (1) set per 12 months under age nineteen and one (1) set per 18 months age nineteen (19) 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 – one (1) per 12 months under age fourteen (14).
6. Space maintainers – one (1) per five (5) year period for Members under age fourteen (14) 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 calendar 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 36 months per area of the mouth.
- Surgical periodontal procedures – one (1) per 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 5 calendar years of previous placement of any of the procedures in this category.
- Buildups and post and cores – not within 5 calendar years of previous placement of any of the procedures in this category.
- Replacement of natural tooth/teeth in an arch – not within 5 calendar years 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 calendar years 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.
13. Root canal retreatment – one (1) per tooth per lifetime.
14.Recementation – one (1) per 3 calendar years.
Recementation during the first 13 calendar year 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 professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.
16. Payment for orthodontic services, if covered, shall cease at the end of the month after termination by the Company.
This limitation does not apply to Group Policies issued and delivered in Maryland.
17. Intraoral films:
· Periodical – four (4) per 12 months per dentist if not performed in conjunction with definitive procedure(s).
· Occlusal – two (2) per 12 months under age eight (8).
18. General anesthesia and IV sedation: a total of 60 minutes per session.