UNITED CONCORDIA® DENTAL

Benefit Summary
Individual 500 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 II/ Basic Services (No Waiting Period)	
• Basic Restorative (Fillings, etc.) • Endodontics (Root canals, etc.) • Simple Extractions	**60%**
Class III/ Major Services (After a six (6) month Waiting Period)	
• 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	**60%**

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.

United Concordia will not accept business submitted by or pay commission to producers who are not appointed. A producer's quotation of rates to individuals or submission of business to United Concordia constitutes acceptance of and agreement to comply with this rule. To review and complete appointment information, visit the Producer section of www.UnitedConcordia.com, select Resources then Appointment Information.

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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 AR, AZ, CA, CO, CT, FL, GA, IN, LA, MA, MI, MS, NM, OH, OK, OR, RI, SC, TN, TX, WA and WV. Benefits are offered under policy number IN01-0309UCIC in AZ, CA, and WV, under IN01-0310UCIC in CO, CT, MI, MS, NM, and SC, under ARIN01-0310UCIC in AR, under FLIN01-0309 in FL, under GAIN01-UCIC0310 in GA, under ININ01-0310UCIC in IN, under LAIN01-0310UCIC in LA, under MAIN01-0310UCIC in MA, under OHIN01-0310UCIC in OH, under OKIN01-0310UCIC in OK, under ORIN01-0310UCIC in OR, under RIIN01-0310UCIC in RI, under TNIN01-0310UCIC in TN, under TXIN01-0309 in TX and under WAIN01-0310UCIC in WA.
- United Concordia Life and Health Insurance Company when issued in DC, DE, KY, MO, NC, NJ and PA. Benefits are offered under policy number IN01-0310UCLH in DE, and KY, under DCIN01-0310UCLH in DC, under MOIN01-0310UCLH in MO, under NCIN01-0310UCLH in NC, under NJIN01-0310UCLH in NJ and under PAIN01-0309 in PA.
- United Concordia Dental Corporation of Alabama when issued in AL. Benefits are offered under policy number IN01-0310UCAL in AL.

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. Not all products are available in all jurisdictions.

The policyholder may return any United Concordia Policy for a full refund of premium, within ten days of its delivery (or 30 days for NC and NJ residents eligible for Medicare by age) 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 GA, MI, NJ, NY, OH, PA, and TN, 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 in accordance with the terms of the policy, including the grace period.

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.

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Why Do I Need Dental Insurance?

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 shown that pregnant women with periodontal disease are at a greater risk for having low-birthweight and preterm births.

In addition to helping protect your oral and overall health, good oral health habits combined with a sensible insurance plan that encourages preventive dental visits can help reduce the chance that you will require more costly, complex dental procedures in the future.

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 coverage levels for your specific needs at prices you can afford. We also negotiate *reduced fees* with our network dentists, which helps you maximize the value of your policy and lower your overall dental bill.
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 IND500
Individual Without Dental Insurance vs. United Concordia Dental Member

		Individual with United Concordia Dental Plan[1]				
Service	**Average Dentist's Charge[2]/Individual Without Dental Insurance Pays Full Amount**	**United Concordia Plan Negotiated Fee[3]**	**Coverage Level**	**United Concordia Pays[4]**	**United Concordia Member Pays[4]**	**Savings for United Concordia Member vs. Individual Without Dental Insurance[4, 5]**
2 Cleanings	$174	$100	0%	$0	$100	$74
2 Exams	$100	$52	0%	$0	$52	$48
1 Set of X-Rays	$58	$31	0%	$0	$31	$27
1 "White" Filling[6]	$152	$84	60%	$50	$34	$118
1 Crown	$965	$644	60%	$386	$258	$707
	$1,449	$911	N/A	$436	$475	**$974**

1. For illustrative purposes only. Assumes coverage levels of 0% for Class I, 60% for Class II and 60% for Class III services and that the deductible (if applicable) has already been met.
2. Average dentist's charge based on internal 2010 data for zip codes 90001-93099; actual charges will vary by dentist, service and geographic region, 07/10.
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 covered service.
4. Assumes services provided by an Advantage *Plus* network dentist. Please note, not all dentists have agreed to hold their charges to the MAC for non-covered services.
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.

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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***. Your policy effective date will be shown on your policy. This is the date when your coverage begins.
We will mail your ID card(s) separately. You will receive one ID card if your policy is just for you and two cards if your policy covers both you and other members of your family.

Frequently Asked Questions

Going to the 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**—Our network dentists accept our negotiated fees as payment in full for covered services. These negotiated fees are typically 10-35% below the average charge for these services in the dentist's geographic area. This means your out-of-pocket savings may be greater when you choose a dentist in our network.
- **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. What is the name of my network under this policy?
A. iDental members use the **Concordia Advantage *Plus*** network. When using **Find a Dentist**, if you are prompted to **Select a Dental Network**, that is the network you will choose. Also, you should inform your dentist that you participate in the **Concordia Advantage *Plus*** network when you call to make an appointment.

Q. How do I find out if my dentist participates in the Concordia Advantage *Plus* network?
A**.** Just use our **Find a Dentist** online search tool. If you are prompted to **Select a Dental Network**, choose **Concordia Advantage *Plus***, then indicate your other search preferences. You can also call Customer Service toll-free at 1-866-568-6099 Monday through Friday between 8 a.m. and 8 p.m. ET.

Q. If my dentist does not participate in the Concordia Advantage *Plus* 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 for consideration, go to **www.UnitedConcordia.com**, enter the **Members** section and click on **Forms.** Then select **Nominate Your Dentist** and complete the requested information.

Q. If my dentist does not participate in the Concordia Advantage *Plus* network, can I still see him/her?
A. Yes, you may receive care from any licensed dentist; however, your out-of-pocket costs may be higher if you visit a non-network dentist.

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Premium, Policy and Billing Questions

Q. Are there waiting periods for certain dental services?

A**.** Certain services may have waiting periods. A waiting period is the period of time between the effective date of a dental plan and the date when a specific group or class of services is considered for benefits. Waiting periods can vary by product. Please review the benefit summary and read the policy documents for more detailed information.

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, which are typically lower. Unless prohibited by law, non-network dentists *can* balance bill you for the difference between their standard charges and the MACs, which may result in higher out-of-pocket costs.

Q. When will you raise my premium rates?

A**.** Your premium rates are guaranteed not to increase for a period of 12 months from the effective date of your policy, 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 a contract year?

A**.** A contract year is the 12-month period beginning on the effective date of your policy and ending on the expiration date of your policy. See your policy documents for details on how to renew your policy if you desire.

Q. What is the annual deductible?

A**.** The annual deductible is the amount each covered member must pay each year before the policy begins to cover benefits. Class I services, if covered by the iDental plan you chose, are exempt from the deductible, so benefit coverage begins immediately for these services. The deductible amount varies by product. Please review the benefit summary and read the policy documents for more detailed information.

Q. What is the annual maximum?

A**.** The annual 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, visit www.iDental.com or call Customer Service at 1-866-568-6099 Monday through Friday 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.