

SERFF Tracking Number:	FRCS-126643128	State:	Arkansas
Filing Company:	United Concordia Insurance Company	State Tracking Number:	45832
Company Tracking Number:	5199		
TOI:	H10I Individual Health - Dental	Sub-TOI:	H10I.000 Health - Dental
Product Name:	Individual Dental Filing		
Project Name/Number:	UCCI/64/64		

Filing at a Glance

Company: United Concordia Insurance Company

Product Name: Individual Dental Filing

SERFF Tr Num: FRCS-126643128 State: Arkansas

TOI: H10I Individual Health - Dental

SERFF Status: Closed-Approved-
Closed State Tr Num: 45832

Sub-TOI: H10I.000 Health - Dental

Co Tr Num: 5199

State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Authors: Jana Ellmaker, Kevin
Wiggs

Disposition Date: 07/08/2010

Date Submitted: 05/28/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: UCCI/64

Status of Filing in Domicile: Authorized

Project Number: 64

Date Approved in Domicile: 08/04/2009

Requested Filing Mode: Review & Approval

Domicile Status Comments: Policy approved
8/4/09, rest of forms on 06/16/09.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 07/08/2010

Explanation for Other Group Market Type:

State Status Changed: 07/08/2010

Deemer Date:

Created By: Jana Ellmaker

Submitted By: Jana Ellmaker

Corresponding Filing Tracking Number:

Filing Description:

We have been retained United Concordia Insurance Company to file the enclosed forms for approval in your state.

Our fee of \$550 has been sent by EFT on this same date.

The Company offers their assurances that the information required by Section 23-79-138 and the Guaranty Association notice required by Regulation 49 will be provided.

SERFF Tracking Number: FRCS-126643128 State: Arkansas
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TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
Product Name: Individual Dental Filing
Project Name/Number: UCCI/64/64

This filing contains an individual dental policy, appeal procedure addendum, schedule of exclusions and limitations, outline of coverage and schedules of benefits (5 versions).
These forms will be combined to create the entire contract.

These forms are new forms and do not replace any existing forms. These forms are intended to be issued to individual insureds.

Please note that a Statement of Variability is not included since variability is limited to the addresses, phone numbers, Policy Schedule, policyholder name, date of birth, effective date, billing frequency, type of coverage, premium rates and dental product selected.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

Company and Contact

Filing Contact Information

Jana Ellmaker, Senior Compliance Specialist jana.ellmaker@firstconsulting.com
1020 Central 800-927-2730 [Phone] 2741 [Ext]
Suite 201 816-391-2755 [FAX]
Kansas City, MO 64105

Filing Company Information

(This filing was made by a third party - FC01)

United Concordia Insurance Company	CoCode: 85766	State of Domicile: Arizona
4401 Deer Path Road	Group Code: 812	Company Type:
Harrisburg, PA 17110	Group Name:	State ID Number:
(717) 260-7231 ext. [Phone]	FEIN Number: 86-0307623	

Filing Fees

Fee Required? Yes
Fee Amount: \$550.00
Retaliatory? No
Fee Explanation: \$50.00 x 10 forms + \$50.00 for rates = \$550.00
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Concordia Insurance Company	\$550.00	05/28/2010	36896046

SERFF Tracking Number: FRCS-126643128 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/08/2010	07/08/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	06/04/2010	06/04/2010	Aaron Clark	06/29/2010	06/29/2010

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Disposition

Disposition Date: 07/08/2010

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
United Concordia Insurance Company	%	%	\$		\$	%	%

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Authorization	Approved-Closed	Yes
Form	Individual Dental Insurance Policy	Approved-Closed	Yes
Form	Schedule of Exclusions and Limitations	Approved-Closed	Yes
Form	Appeal Procedure Addendum	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form (<i>revised</i>)	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Replaced	Yes
Rate	Rates	Approved-Closed	Yes

SERFF Tracking Number: FRCS-126643128 State: Arkansas
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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 06/04/2010

Submitted Date 06/04/2010

Respond By Date

Dear Jana Ellmaker,

This will acknowledge receipt of the captioned filing.

Objection 1

- Enrollment Form, INAPP-0309 (Form)

Comment:

Arkansas must also have a Fraud Statement in the application/enrollment form. Please refer to ACA 23-66-503.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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 Product Name: Individual Dental Filing
 Project Name/Number: UCCI/64/64

Response Letter

Response Letter Status Submitted to State
 Response Letter Date 06/29/2010
 Submitted Date 06/29/2010

Dear Rosalind Minor,

Comments:

In response to your objection letter dated 6/4/2010, on behalf of United Concordia Insurance Company, we offer the following for your consideration.

Response 1

Comments: Form number "ARINAPP-0309" is attached for review. This revision required a change in the form number.

Related Objection 1

Applies To:

- Enrollment Form, INAPP-0309 (Form)

Comment:

Arkansas must also have a Fraud Statement in the application/enrollment form. Please refer to ACA 23-66-503.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Enrollment Form	ARINAPP-0309		Application/Enrollment Form	Initial		50.000	AR Individual Enrollment .pdf
Previous Version							
Enrollment Form	INAPP-0309		Application/Enrollment Form	Initial		50.000	individual_enrollment

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Product Name: *Individual Dental Filing*
Project Name/Number: *UCCI/64/64*

6 (2).pdf

No Rate/Rule Schedule items changed.

We trust this information will allow you to finalize review of this filing. If you need any further information or have any questions, please call toll-free 1-800-927-2730. Thank you for your assistance.

Sincerely,
Jana Ellmaker, Kevin Wiggs

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Form Schedule

Lead Form Number: ARIN01-0310UCIC

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/08/2010	ARIN01-0310UCIC	Policy/Contract	Individual Dental Insurance Policy Certificate	Initial		50.800	AR UCIC Individual Policy Final 2010 050710.pdf
Approved-Closed 07/08/2010	INEL1-0309	Policy/Contract	Schedule of Exclusions and Limitations Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		51.200	Individual Es & Ls - Final_dist.pdf
Approved-Closed 07/08/2010	INAPL-0309	Policy/Contract	Appeal Procedure Addendum Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		50.000	Individual APPEAL PROCEDUR E--Final 030409_dist.pdf
Approved-Closed 07/08/2010	INS-1-0309	Schedule Pages	Schedule of Benefits	Initial		50.000	Individual Dental Plan IND100 (distilled).pdf
Approved-Closed 07/08/2010	INS-2-0309	Schedule Pages	Schedule of Benefits	Initial		50.000	Individual Dental Plan IND200 (distilled).pdf

<i>SERFF Tracking Number:</i>	<i>FRCS-126643128</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>United Concordia Insurance Company</i>	<i>State Tracking Number:</i>	<i>45832</i>
<i>Company Tracking Number:</i>	<i>5199</i>		
<i>TOI:</i>	<i>H101 Individual Health - Dental</i>	<i>Sub-TOI:</i>	<i>H101.000 Health - Dental</i>
<i>Product Name:</i>	<i>Individual Dental Filing</i>		
<i>Project Name/Number:</i>	<i>UCCI/64/64</i>		
Approved- Closed 07/08/2010	INS-3-0309 Schedule Pages	Schedule of Benefits Initial	50.000 Individual Dental Plan IND300 (distilled).pdf
Approved- Closed 07/08/2010	INS-4-0309 Schedule Pages	Schedule of Benefits Initial	50.000 Individual Dental Plan IND400 (distilled).pdf
Approved- Closed 07/08/2010	INS-5-0309 Schedule Pages	Schedule of Benefits Initial	50.000 Individual Dental Plan IND500 (distilled).pdf
Approved- Closed 07/08/2010	ARINOC- 0309UCIC Outline of Coverage	Outline of Coverage Initial	AR UCIC Individual Outline of Coverage Final 050710.pdf
Approved- Closed 07/08/2010	ARINAPP- 0309 Application/ Enrollment Form	Application/Enrollment Form Initial	50.000 AR Individual Enrollment.pdf

**UNITED CONCORDIA INSURANCE COMPANY
(HEREINAFTER REFERRED TO AS COMPANY)**

{4401 DEER PATH ROAD}

{HARRISBURG, PA 17110}

{#-###-###-####}

**INDIVIDUAL DENTAL INSURANCE POLICY
LIMITED BENEFIT HEALTH INSURANCE COVERAGE**

This Policy is non-participating and provides benefits for dental care only. It does not pay benefits for any other type of loss.

READ THE POLICY CAREFULLY FOR DETAILS ON THE DENTAL INSURANCE COVERAGE. This policy is a legal contract between You and the Company.

CONSUMER NOTICE

If the Policyholder has any questions or concerns about this coverage, the Policyholder should contact the Company, at the address or phone number shown in this Policy, or contact our designated administrator. If the Company is not able to provide a satisfactory resolution to the inquiry, the

Policyholder may contact the:

Arkansas Department of Insurance

Consumer Services

1200 W. Third Street

Little Rock, AR 72201-1904

800-852-5494

501-371-2640

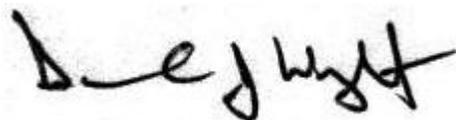
NOTICE OF RIGHT TO EXAMINE POLICY FOR 10 DAYS: The Policyholder may return this Policy within ten days of its delivery if, after examination of the Policy, the Policyholder is not satisfied with it for any reason. Upon return, the Company will refund all Premium paid. The Policy shall be void from the beginning and the parties shall be in the same position as if no policy had been issued.

THIS POLICY IS CONDITIONALLY RENEWABLE: This Policy is renewable for one year terms as long as full Premium is paid when due unless one of the reasons detailed under the Policy Term and Renewal section occurs. If any one of such reasons occurs, the Company reserves the right to not renew or to terminate the Policy. Premiums may change at Policy renewal as detailed in the Policy Term and Renewal section.

AGREEMENT AND CONSIDERATION: In consideration of payment of all Premiums when due and receipt of accurate and complete application information, the Company will insure the Policyholder named on the Policy Schedule attached hereto and his/her enrolled Dependents for dental benefits in accordance with the terms and conditions of this Policy. Coverage will begin at 12:01 AM on the Effective Date shown on the Policy Schedule. It will remain in force until the first Renewal Date, and for such further periods for which it is renewed.



Company Officer
ARIN01-0310UCIC



Company Officer

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Attached Forms incorporated by reference into this Policy:

- Schedule of Benefits
- Schedule of Exclusions and Limitations
- Appeal Procedure Addendum

DEFINITIONS

Certain terms used throughout this Policy begin with capital letters. When these terms are capitalized, they have the meanings set forth below.

Company - United Concordia, the insurer shown on the front page of this Policy. Also referred to as “We”, “Our” or “Us”.

Coinsurance - Those remaining percentages or dollar amounts of the Maximum Allowable Charge for a Covered Service that are the responsibility of the Insured Person after the Company pays the percentages or dollar amounts shown on the Schedule of Benefits for a Covered Service.

Covered Service(s) – Services 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 Insured Person before the Company will pay any benefit.

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

Effective Date - The date on which the Policy begins or coverage of an Insured Person begins.

Exclusion(s) – Services, supplies or charges that are not covered under the Policy as stated in the Schedule of Exclusions and Limitations attached to this Policy.

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

Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during a specified period as shown on the Schedule of Benefits.

Maximum Allowable Charge - The greatest amount the Policy will allow for a specific service.

Insured Person(s) - Policyholder and enrolled dependents.

Non-Participating Dentist - A Dentist who has not contracted with the Company or its affiliate to limit his/her charges.

Participating Dentist - A Dentist who has executed a Participating Dentist Agreement with the Company or an affiliate of the Company, under which he/she agrees to accept the Company’s Maximum Allowable Charges as payment in full for Covered Services.

Policy (“Policy”) - This document, including riders, schedules, addenda and/or endorsements, if any, which are attached to the Policy and describe the dental insurance purchased from the Company.

Policyholder(s) - The individual named on the Policy schedule who has purchased this dental insurance for him/herself and any Dependents. Also referred to as “You” or “Your” or “Yourself”.

Premium - Payment that must be remitted in exchange for coverage of the Policyholder and his/her Dependents.

Renewal Date - The date the Policy renews.

Schedule of Benefits - Attached summary of Covered Services, Policy payment percentages, Deductibles, benefit Waiting Periods and Maximums applicable to benefits payable under the Policy.

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

State Law Provisions Addendum – Attached document containing specific provisions required by state law to be modified, deleted from, and/or added to the Policy.

Termination Date - The date on which the dental coverage ends for an Insured Person or on which the Policy terminates.

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

ELIGIBILITY AND EFFECTIVE DATE

In order to become insured, You must supply information on Yourself and Your Dependents, select a dental product, payment method, and billing frequency. Your coverage and Your Dependents' coverage will begin on the first day of the month following receipt of enrollment. We reserve the right to require proof of dependency. An identification (ID) card will be provided indicating Your unique identification number (Policy number).

“Dependents” eligible for coverage include:

1. Your spouse or domestic partner as defined by any applicable state law; and
2. Any unmarried natural child or stepchild or adopted child or child placed by order of a court or administrative agency:
 - (a) until the end of the month which he/she reaches age 26; or
 - (b) to any age if he/she is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Policyholder for maintenance and support.

After Your Effective Date, You may add Dependents if they meet the requirements detailed above and You supply the required change information. Except for newborn or adoptive children, coverage for the new Dependent will begin on the first day of the month following receipt of enrollment information. Your bill or payment will be adjusted for the additional Premium.

Newborn children of a Policyholder will be considered insured from the moment of birth. In order for coverage of newly born children to continue beyond the first 90 day period, the child's change information must be provided and the required Premium must be paid as required on the next bill. Adoptive children will be considered insured from the date of the filing of a petition for adoption if You apply for coverage within 60 days after the filing of the petition for adoption. However, if the petition for adoption and application for coverage is filed within 60 days after the birth, such children will be considered insured Dependents from the moment of birth. In order for coverage of adoptive children to continue beyond the first 60 day period, the child's change information must be provided and the required Premium must be paid as required on the next bill.

Dependent coverage will end at 12:00 midnight the last day of the month during which:

1. for a Dependent spouse, We receive notice that You as the Policyholder become legally divorced.
2. for a domestic partner, We receive a request from You to discontinue coverage.
3. for Dependent children, they no longer meet the requirements detailed above.

Notification of divorce or cessation of a domestic partnership must be supplied immediately upon occurrence of the event. Any applicable adjustment to Premium for termination of a Dependent's coverage will be included on Your next bill.

For an enrolled Dependent child who is mentally or physically handicapped, evidence of his/her reliance on You for maintenance and support due to his/her condition must be supplied within 60 days of Our request. Such evidence

will be based on information provided by the Insured Person's physician and will be requested no more frequently than annually.

CONVERSION

In the event of Your divorce or a child reaching the limiting age previously described, Your former spouse or child may apply for a Policy if the former spouse or child was insured at the time of the event. The spouse or child must apply within 60 days of the date his/her insurance terminated and pay the required Premium to avoid any lapse in coverage.

If this Policy covers only an individual Policyholder and he/she dies, We will refund any unearned Premium based on the number of full months that remain until the next Premium due date. In the event the Policy covers Dependents at the time of the Policyholder's death, his/her surviving spouse will become the Policyholder, and Premium will be adjusted accordingly. A surviving spouse not covered at the time of death may apply for a Policy as a new individual Policyholder.

PREMIUM PAYMENT

The Premium rate(s) shown on the Policy Schedule are payable on the due date on the bill. Premium is expected to be paid timely and in full. The frequency and payment method are chosen at the time of purchase. From time to time, the Company may change the rate tables used for Premium calculation. The dental plan chosen, billing frequency, age, and place of residence are factors used in determining initial Premium rates. Premiums will be based on the rate table in effect on Your Renewal Date. The Company will make no change in your Premium solely because of claims made under this Policy. The Company reserves the right to seek reimbursement from the Policyholder for any bank charges incurred for insufficient funds on a payment by the Policyholder.

Grace Period: If Premium is not paid by the due date indicated on the bill, a grace period of 31 days will be granted for payment of the overdue Premium. If payment is not remitted by the end of the grace period, the Policy will terminate and coverage will end at the conclusion of the period for which the last Premium payment was made for You and/or Your Dependents. The grace period will not apply if, at least 30 days before the due date, We have delivered or mailed to your last known address written notice of our intent not to renew this Policy.

Reinstatement: If any renewal Premium is not paid within the grace period for payment, a subsequent acceptance of Premium by the Company or by any agent duly authorized by the Company to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy. However, if the Company requires an application for reinstatement and issues a conditional receipt for the Premium, the Policy will be reinstated upon approval of such application by the Company. Lacking such approval, the Policy will be reinstated upon the 45th day following the date of such conditional receipt unless the Company has previously notified the Policyholder in writing of its disapproval of such application. The Policyholder and Company shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Misstatement of Age: If the age of the Insured Person has been misstated, all benefits payable under this Policy shall be such as the Premium paid would have purchased at the correct age. In the event the age of an Insured Person has been misstated and according to the correct age of the Insured Person, the coverage provided by the Policy would not have become effective or would have ceased prior to the acceptance of Premium for the Insured Person, the liability of the Company shall be limited to the refund, upon request, of all Premiums paid for the period the Insured Person was not covered under the Policy.

POLICY TERM AND RENEWAL

The term of this Policy is one year beginning at 12:01 AM on the Effective Date shown on the Policy Schedule. The Policy shall renew from year to year if full Premiums are paid timely subject to the following:

1. We will provide at least 60 days advance notice of any change in Premium at renewal.
2. You as the Policyholder may elect not to renew the Policy on Your Renewal Date. If You elect not to renew, You will not be permitted to apply for new dental insurance for Yourself or Your Dependents for three (3) years from the Termination Date.
3. You as the Policyholder may change dental products at renewal by notifying Us. Replacement Schedules of Benefits and Exclusions and Limitations depicting the product choice will be supplied to You. Any applicable benefit Waiting Periods will be applied as if You are a new Policyholder. Any change in Premium will be included on Your next bill.
4. We may elect not to renew the Policy with 60 days advance notice if any of the following occur:
 - a) Fraud or material misrepresentation by or with the knowledge of You as the Policyholder or an insured Dependent applying for this coverage or filing a claim for benefits;
 - b) You as the Policyholder or an insured Dependent engages in intentional and abusive noncompliance with material provisions of the Policy;
 - c) The Company ceases to renew all policies issued on this form to residents of the state where the Policyholder lives.

No benefits will be paid for expenses incurred during any period of time for which Premium has not been paid.

POLICY TERMINATION

The Policy will terminate and all coverage will cease when any of the events detailed in this Section occur.

1. We may terminate the Policy for nonpayment of Premiums when due, subject to the Grace Period provision.
2. You as the Policyholder may terminate the Policy by sending a written notice. The termination will be effective on the first day of the month following the date requested in Your written notification unless Premium is owed. If Premium is owed, Policy termination will be effective the first day of the month following the conclusion of the last period for which you paid Premium. If You elect to terminate the Policy, You will not be permitted to re-enroll Yourself or Your Dependents for three (3) years from the Termination Date.
3. We decline to renew the Policy as provided by Provision 4 of the above renewal clause; or
4. The Policyholder dies, if this Policy covered only that individual.

Benefits After Coverage Terminates: We are not liable to pay any benefits for services which are started after the Termination Date of an Insured Person's coverage or of the Policy. However, coverage for completion of a dental procedure requiring two or more visits on separate days will be extended for a period of 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. This extension does not apply if the Policy terminates for failure to pay Premium.

BENEFITS

Choice of Provider

You may choose any licensed Dentist for services. However, if You choose a Participating Dentist, You may limit Your out-of-pocket cost. Participating Dentists limit their fees to their contracted Maximum Allowable Charges for Covered Services. Participating Dentists also complete and send claims for Covered Services directly to Us for processing. To find a Participating Dentist, visit Our website at {www.unitedconcordia.com} or call the toll-free number on Your ID card.

If You go to a Dentist who is not a United Concordia 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 costs.

Schedule of Benefits

Your benefits are shown on the attached Schedule of Benefits. The Schedule of Benefits shows:

- the classes of dental services covered.
- the percentage the Policy will pay.
- any Waiting Periods, measured from the Insured Person's Effective Date that must be satisfied before the Policy will pay benefits for particular services.
- any Deductibles You and/or Your family must pay before any benefits for Covered Services will be paid. The Deductible is applied only to expenses for Covered Services on a contract year basis (yearly period beginning with the Effective Date of Your Policy).
- any annual Maximums applied on a contract year basis.

Exclusions and Limitations

No benefits will be provided for services, supplies or charges detailed under the Exclusions on the Schedule of Exclusions and Limitations. Services shown on the Schedule of Benefits as covered are subject to frequency or age Limitations detailed on the attached Schedule of Exclusions and Limitations.

Payment of Benefits

If You have treatment performed by a Participating Dentist, We will send payment for Covered Services directly to the Participating Dentist. Both You and the Dentist will be notified of benefits covered, our payment and any amounts You owe for Coinsurance, Deductibles, charges exceeding annual Maximums or charges for services not covered. Payment will be based on the Maximum Allowable Charge the treating Participating Dentist has contracted to accept. Maximum Allowable Charges may vary depending on the geographical area of the dental office and the contract between the Company and the particular Participating Dentist rendering the service. Participating Dentists agree by contract to accept Maximum Allowable Charges as payment in full for Covered Services rendered to Insured Persons.

If You receive treatment from a Non-Participating Dentist, We will send payment for Covered Services to You unless You indicate on the claim that You wish payment to be sent directly to Your treating Dentist. This is called assignment of benefits, and it is available for care delivered by Non-Participating Dentists outside of Pennsylvania or West Virginia. You will still be notified of the services covered, our payment and any amounts owed for Coinsurance, Deductibles, charges exceeding annual Maximums or charges for services not covered. Our payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the Dentist any difference between our payment and the Dentist's full charge for the services. Non-Participating Dentists are not obligated to limit their fees to Our Maximum Allowable Charges.

We are not liable to pay benefits for any services started prior to an Insured Person's Effective Date of coverage. Multi-visit procedures are 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. Procedures started prior to the Insured Person's Effective Date are the liability of the Insured Person.

This Policy does not coordinate benefits with other dental plans.

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 on the front of this Policy 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 Policy for further steps You can take regarding Your claim.

CLAIM PROVISIONS

Notice of Claim

Written notice of claim must be given to the Company within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Insured Person to the Company, or to any authorized agent of the Company, with information sufficient to identify the Insured Person, shall be deemed notice to the Company.

Claim Forms

The Company, upon receipt of a notice of claim, will furnish to the Insured Person such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after the Company received notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to the Company at its said office 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 (1) year from the time proof is otherwise required.

The acknowledgment by the Company of the receipt of notice given or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the Company in defense of any claim arising under such Policy.

Time Payment of Claims

All benefits payable under this Policy for any loss will be paid immediately (and no later than thirty (30) calendar days) after receipt of due written proof of such loss.

Payment of Claims

All benefits under this Policy shall be payable to the Participating Dentist or the Insured Person, or to his designated beneficiary or beneficiaries, or to his estate, except that if the Insured Person is a minor or otherwise not competent

to give a valid release, such benefits may be made payable to his custodial parent, guardian, or other person actually supporting him. All or a portion of any indemnities provided by this Policy on account of dental services may, at the option of the Company and unless the Insured Person requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Participating Dentist office rendering such services.

Physical Examinations

The Company at its own expense shall have the right and opportunity to examine an Insured Person when and as often as it may reasonably require during the pendency of a claim hereunder.

GENERAL PROVISIONS

Entire Contract: Changes

This Policy includes and incorporates any and all riders, endorsements, addenda, and schedules and together they represent the entire contract between the Policyholder and the Company. The failure of any section or subsection of this Policy shall not affect the validity, legality and enforceability of the remaining sections.

No change in this policy will be effective until approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

Time Limit On Certain Defenses

There will be no contest of the validity of the Policy, except for not paying Premiums, after it has been in force two (2) years after the Effective Date.

Assignment

We may assign this Policy and its rights and obligations hereunder to any entity under common control with the Company.

Legal Actions

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty (60) days after written proof of loss has been filed in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Conformity With State Laws

Any part of the Policy in conflict with the laws of the state where You live on the Policy's Effective Date is changed to conform to the minimum requirements of that state's law. After the Effective Date, the Policy may be amended with at least 60 days notice without mutual agreement of the parties if the change is necessary to satisfy the requirements of any applicable state or federal law. Such amendment will not affect a claim incurred prior to the effective date of the change.

Privacy

We do not disclose claim or eligibility records except as allowed or required by law and then in accordance with federal and state law. We maintain physical, electronic, and procedural safeguards to guard claims and eligibility information from unauthorized access, use, and disclosure.

POLICY SCHEDULE

<i>Policyholder Name & Date of Birth:</i>	{John Doe}	{XX/XX/XXXX}
<i>Policy Number:</i>	As shown on your ID card	
<i>Effective Date:</i>	{XX/XX/XXXX}	
<i>Billing Frequency:</i>	{Monthly, Quarterly, Semi-Annually, Annually}	
<i>Type of Coverage & Premium Rates:</i>	{Policyholder only}	{\$ 12.34}
	{Policyholder and One Dependent}	{\$ 45.67}
	{Family}	{\$100.00}
<i>Dental Product Selected:</i>	Plan {XXXXXX, XXXXXX, XXXXXX, XXXXXX, XXXXXX}	

Schedule of Exclusions and Limitations

This Schedule describes services, supplies or charges that are excluded from coverage (Exclusions), or for which coverage is limited by age or frequency (Limitations), subject to any applicable provisions in the State Law Provisions Addendum attached to this Policy. Only American Dental Association procedure codes may be billed under this Policy.

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.

INDIVIDUAL DENTAL INSURANCE POLICY ADDENDUM

APPEAL PROCEDURE

This Addendum is attached to and made part of the Policy.

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

“Adverse Benefit Determination” is a denial, reduction, or failure to make payment (in whole or in part) of a claim due to lack of eligibility for coverage, policy limitations or exclusions, or a determination that an item or service otherwise covered is experimental or investigational or not dentally necessary or appropriate.

“Authorized Representative” is a person granted authority by You and the Company to act on Your behalf regarding a claim for benefit 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.

If You are dissatisfied with Our benefit determination on a claim, You 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 Policy 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.

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 Policy 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 the Policy provisions on which the decision was based; and
- c) a statement that You are entitled to receive upon request and free of charge, 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.

Schedule of Benefits

Annual Deductible Per Insured Person	\$0 Per Contract Year
Annual Maximum Per Insured Person	Unlimited Per Contract Year
Policy Pays	
Class I / Diagnostic and Preventive Services (No Waiting Period)	
• Exams	100%
• All X-Rays	100%
• Cleanings	100%
• Fluoride Treatments	100%
• Sealants	100%
• Palliative Treatment (Emergency)	100%
Class II / Basic Services	
• Space Maintainers	0%
• Periodontal Maintenance	0%
• Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	0%
• Basic Restorative (Fillings, etc.)	0%
• Endodontics (Root canals, etc.)	0%
• Simple Extractions	0%
Class III / Major Services	
• Complex Oral Surgery	0%
• General Anesthesia and/or Nitrous Oxide and/or IV Sedation	0%
• Non-surgical Periodontics	0%
• Surgical Periodontics	0%
• Crowns, Inlays, Onlays	0%
• Prosthetics (Fixed Partial Dentures, Dentures)	0%
• Implants	0%

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 Non-Participating Dentist.

Participating Dentists accept the Maximum Allowable Charge as payment in full. Non-Participating Dentists may bill you for the difference between their charge and the Maximum Allowable Charge paid by the Policy.

All services listed on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations.

Schedule of Benefits

Annual Deductible Per Insured Person (Applies to Class II)	\$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)	
• Exams	100%
• All X-Rays	100%
• Cleanings	100%
• Fluoride Treatments	100%
• Sealants	100%
• Palliative Treatment (Emergency)	100%
Class II / Basic Services (No Waiting Period)	
• Space Maintainers	80%
• Periodontal Maintenance	80%
• Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	80%
• Basic Restorative (Fillings, etc.)	80%
• Endodontics (Root canals, etc.)	80%
• Simple Extractions	80%
Class III / Major Services	
• Complex Oral Surgery	0%
• General Anesthesia and/or Nitrous Oxide and/or IV Sedation	0%
• Non-surgical Periodontics	0%
• Surgical Periodontics	0%
• Crowns, Inlays, Onlays	0%
• Prosthetics (Fixed Partial Dentures, Dentures)	0%
• Implants	0%

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 Non-Participating Dentist.

Participating Dentists accept the Maximum Allowable Charge as payment in full. Non-Participating Dentists may bill you for the difference between their charge and the Maximum Allowable Charge paid by the Policy.

All services listed on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations.

Schedule of Benefits

Annual Deductible Per Insured Person (Applies to Class II)	\$50 Per Contract Year
Annual Maximum Per Insured Person	\$1,500 Per Contract Year
Policy Pays	
Class I / Diagnostic and Preventive Services (No Waiting Period)	
• Exams	50%
• All X-Rays	50%
• Cleanings	50%
• Fluoride Treatments	50%
• Sealants	50%
• Palliative Treatment (Emergency)	50%
Class II / Basic Services (No Waiting Period)	
• Space Maintainers	50%
• Periodontal Maintenance	50%
• Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	50%
• Basic Restorative (Fillings, etc.)	50%
• Endodontics (Root canals, etc.)	50%
• Simple Extractions	50%
Class III / Major Services	
• Complex Oral Surgery	0%
• General Anesthesia and/or Nitrous Oxide and/or IV Sedation	0%
• Non-surgical Periodontics	0%
• Surgical Periodontics	0%
• Crowns, Inlays, Onlays	0%
• Prosthetics (Fixed Partial Dentures, Dentures)	0%
• Implants	0%

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 Non-Participating Dentist.

Participating Dentists accept the Maximum Allowable Charge as payment in full. Non-Participating Dentists may bill you for the difference between their charge and the Maximum Allowable Charge paid by the Policy.

All services listed on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations.

Schedule of Benefits

Annual Deductible Per Insured Person (Applies to Class II and III Services)	\$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)	
• Exams	100%
• All X-Rays	100%
• Cleanings	100%
• Fluoride Treatments	100%
• Sealants	100%
• Palliative Treatment (Emergency)	100%
Class II / Basic Services (No Waiting Period)	
• Space Maintainers	80%
• Periodontal Maintenance	80%
• Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	80%
• Basic Restorative (Fillings, etc.)	50%
• Endodontics (Root canals, etc.)	50%
• Simple Extractions	50%
Class III / Major Services (after a twelve (12) month Waiting Period)	
• Complex Oral Surgery	50%
• General Anesthesia and/or Nitrous Oxide and/or IV Sedation	50%
• Non-surgical Periodontics	50%
• Surgical Periodontics	50%
• Crowns, Inlays, Onlays	50%
• Prosthetics (Fixed Partial Dentures, Dentures)	50%
• 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 Non-Participating Dentist.

Participating Dentists accept the Maximum Allowable Charge as payment in full. Non-Participating Dentists may bill you for the difference between their charge and the Maximum Allowable Charge paid by the Policy.

All services listed on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations.

Schedule of Benefits

Annual Deductible Per Insured Person (Applies to Class II and Class 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.)	60%
• Endodontics (Root canals, etc.)	60%
• Simple Extractions	60%
Class III / Major Services (after a six (6) month Waiting Period)	
• Complex Oral Surgery	60%
• General Anesthesia and/or Nitrous Oxide and/or IV Sedation	60%
• Non-surgical Periodontics	60%
• Surgical Periodontics	60%
• Crowns, Inlays, Onlays	60%
• Prosthetics (Fixed Partial Dentures, Dentures)	60%
• 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 Non-Participating Dentist.

Participating Dentists accept the Maximum Allowable Charge as payment in full. Non-Participating Dentists may bill you for the difference between their charge and the Maximum Allowable Charge paid by the Policy.

All services listed on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations.

United Concordia Insurance Company
{4401 Deer Path Road, Harrisburg, PA 17110}
Toll Free Member Services Telephone Number: {#-###-###-####}
Web site: {www.unitedconcordia.com}

OUTLINE OF COVERAGE
LIMITED BENEFIT HEALTH COVERAGE
INDIVIDUAL DENTAL POLICY

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY.** This Policy provides benefits for dental care only. It does not pay benefits for any other type of loss such as medical or hospital expenses.

Renewal and Premium Changes	
Renewal	The policy will renew from year to year as long as premium is paid timely unless we elect not to renew the policy with 60 days advance notice if any of the following occur: fraud or material misrepresentation by or with the knowledge of you as the policyholder or an insured dependent applying for this coverage or filing a claim for benefits; you as the policyholder or an insured dependent engages in intentional and abusive noncompliance with material provisions of the policy; or we cease to renew all policies issued on this form to residents of the state where you live. You may elect not to renew the policy on your renewal date. We will provide at least 60 days advance notice of any change in premium at renewal. You may change plan options at renewal by notifying us 31 days in advance of the renewal date.
Right to Change Premium	We may change premium at renewal. We will provide at least 60 days advance notice of any change in premium at renewal.
Description of Coverage	
Benefits	The policy will pay benefits shown on the schedule of benefits subject to exclusions and limitations and other terms included in the policy. Payment is based on the maximum allowable charge for the specific service. Participating dentists accept their contracted maximum allowable charge as payment in full for services. Non-participating dentists do not limit their charges for services. To find a participating dentist, visit our website at { www.unitedconcordia.com }.
Services	Several plan options are available. Your plan may cover: <ul style="list-style-type: none"> • Class I/Diagnostic and Preventive Services, or • Class I/Diagnostic and Preventive Services and Class II/Basic Services, or • Class I/Diagnostic and Preventive Services, Class II/Basic Services and Class III/Major Services, or • Class II/Basic Services and Class/III Major Services Refer to the schedule of benefits in your policy to determine the services included in your plan and the percentage the policy will pay.
Annual Deductible	Your chosen plan option may have a contract year deductible (portion of covered expenses you must pay before the policy will pay benefits). Refer to the schedule of benefits in your policy to determine if your plan has a deductible.
Annual Maximums	Your chosen plan option may have an annual maximum per contract year (a dollar amount for a period of time after which no benefits are paid). Refer to the schedule of benefits in your policy to determine if your plan has a maximum.

Waiting Periods	The plan option you choose may have a waiting period on benefits (a period of time you must be enrolled before certain benefits are covered). Check your schedule of benefits in your policy for any applicable waiting periods.
Exclusions and Limitations	<p>Plan exclusions include but are not limited to:</p> <ul style="list-style-type: none"> • house or hospital calls for dental services; • hospitalization costs; • prescription and non-prescription drugs; • vitamins or dietary supplements; • cosmetic dentistry; • treatment for fractures and dislocations of the jaw; • treatment of malignancies or neoplasms; • services and/or appliances to alter the vertical dimension or restore structure lost from attrition; • periodontal splinting; • plaque control programs, tobacco counseling, oral hygiene and dietary instructions; • treatment and appliances for bruxism; • and specialized procedures and techniques. <p>Services limited by age and/or frequency include but are not limited to:</p> <ul style="list-style-type: none"> • x-rays; • exams; • cleanings; • fluoride treatment; • space maintainers; • sealants; • periodontal services; • fillings; • single crowns, inlays, onlays; • denture relining, rebasing or adjustments; • pulpal therapy; • root canal retreatment; • recementation; • and dental implants. <p>The policy has an alternate benefit provision (ABP) that limits payment to the less costly professionally acceptable procedure.</p> <p>Please see the schedule of exclusions and limitations in the policy for a full list of exclusions and limitations.</p>
Pre-existing Condition Limitations	There are no pre-existing condition limitations under this policy.

IMPORTANT: In the event of any inconsistency between this Outline of Coverage and the Policy, the terms of the Policy will control.

SECTION A: POLICYHOLDER'S INFORMATION			Requested Effective Date		
Social Security Number			Phone Number		
Policyholder's Name (Last, First, Middle Initial, Suffix)			Date of Birth		Gender
Home Address			City	State	Zip Code
Email Address					

SECTION B: DEPENDENT INFORMATION						
Social Security Number	Type	Last Name	First Name	MI	Gender	Date of Birth
	Spouse/ Domestic Partner					
	Dependent (A)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (B)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (C)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (D)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>

Replacement of Coverage – Is this insurance intended to replace ANY current dental insurance? Yes No **If yes, complete the following:**

Insurance Company Name: _____ **Policy Number:** _____

SECTION C: GENERAL INFORMATION		
Premium Payment Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually	My Individual Dental Insurance will be covering: <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Self and one dependent <hr/> Premium Payment (\$):	Plan Selection: <input type="checkbox"/> IND 100 <input type="checkbox"/> IND 400 <input type="checkbox"/> IND 200 <input type="checkbox"/> IND 500 <input type="checkbox"/> IND 300

I represent that all information supplied in this application is true and correct. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

Policyholder's Signature _____ **Date** _____

SECTION D: PRODUCER / AGENCY / GENERAL AGENT (IF APPLICABLE)		
Producer Name		Social Security Number
United Concordia Producer ID Number	State	License Number
Signature		Date
Agency Name		Agency Tax ID Number
United Concordia Producer ID Number	State	License Number
General Agent Name		General Agent Tax ID Number
United Concordia Producer ID Number	State	License Number

APPLICABLE STATE MANDATED PROVISIONS

- AR & LA:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- CA:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.
- FL:** Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
- KS:** Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.
- MD:** Any person who knowingly presents a false or fraudulent claim form for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- NJ:** All statements made by applicant are true and complete to the best of the applicant's knowledge and belief. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

- NY:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- OR:** Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.
- PA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- TN:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- VA:** Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.
- WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

UNITED CONCORDIA OPERATES AS A WHOLLY OWNED SUBSIDIARY UNDER THE NAME LISTED BELOW IN THE FOLLOWING STATES:

- United Concordia Dental Corporation of Alabama—AL
- United Concordia Insurance Company—AK, AR, AZ, CA, CO, CT, FL, GA, HI, IA, ID, IN, KS, LA, MA, ME, MI, MN, MS, MT, NE, NH, NV, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WV, WY
- United Concordia Life and Health Insurance Company—DE, DC, IL, KY, MD, MO, NC, NJ, PA
- United Concordia Insurance Company of New York—NY

SERFF Tracking Number: FRCS-126643128
 Filing Company: United Concordia Insurance Company
 Company Tracking Number: 5199
 TOI: H101 Individual Health - Dental
 Product Name: Individual Dental Filing
 Project Name/Number: UCCI/64/64

State: Arkansas
 State Tracking Number: 45832
 Sub-TOI: H101.000 Health - Dental

Rate Information

Rate data applies to filing.

Filing Method: Approval
Rate Change Type: %
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
United Concordia Insurance Company	%	%				%	%

<i>SERFF Tracking Number:</i>	<i>FRCS-126643128</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>United Concordia Insurance Company</i>	<i>State Tracking Number:</i>	<i>45832</i>
<i>Company Tracking Number:</i>	<i>5199</i>		
<i>TOI:</i>	<i>H101 Individual Health - Dental</i>	<i>Sub-TOI:</i>	<i>H101.000 Health - Dental</i>
<i>Product Name:</i>	<i>Individual Dental Filing</i>		
<i>Project Name/Number:</i>	<i>UCCI/64/64</i>		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action: *	Rate Action Information:	Attachments
Approved-Closed 07/08/2010	Rates	ARIN01-0310UCIC	New		AR Rates.pdf

United Concordia Insurance Co.
 Individual Dental Policy ARIN01-0310UCIC
 Arkansas Zip Codes 716-729
 Policy Effective Dates 10/1/2010 - 12/31/2011

Monthly Rates, Attained Age Under 50

Plan	IND100	IND200	IND300	IND400	IND500
Single	\$19.04	\$33.94	\$22.87	\$43.55	\$35.88
2-Party	\$37.57	\$67.07	\$45.10	\$86.05	\$70.91
Family	\$57.04	\$101.90	\$68.54	\$130.80	\$107.77

Monthly Rates, Attained Age 50 or Greater

Plan	IND100	IND200	IND300	IND400	IND500
Single	\$19.04	\$42.87	\$28.89	\$55.01	\$45.32
2-Party	\$37.57	\$84.72	\$56.97	\$108.70	\$89.57
Family	\$57.04	\$128.71	\$86.58	\$165.21	\$136.13

Quarterly Rates, Attained Age Under 50

Plan	IND100	IND200	IND300	IND400	IND500
Single	\$55.47	\$98.88	\$66.63	\$126.87	\$104.52
2-Party	\$109.44	\$195.39	\$131.37	\$250.68	\$206.55
Family	\$166.14	\$296.82	\$199.68	\$381.00	\$313.95

Quarterly Rates, Attained Age 50 or Greater

Plan	IND100	IND200	IND300	IND400	IND500
Single	\$55.47	\$124.89	\$84.15	\$160.23	\$132.03
2-Party	\$109.44	\$246.78	\$165.96	\$316.65	\$260.91
Family	\$166.14	\$374.94	\$252.21	\$481.26	\$396.57

Semi-Annual Rates, Attained Age Under 50

Plan	IND100	IND200	IND300	IND400	IND500
Single	\$107.70	\$192.06	\$129.42	\$246.42	\$203.04
2-Party	\$212.58	\$379.50	\$255.18	\$486.90	\$401.22
Family	\$322.74	\$576.54	\$387.84	\$740.04	\$609.78

Semi-Annual Rates, Attained Age 50 or Greater

Plan	IND100	IND200	IND300	IND400	IND500
Single	\$107.70	\$242.58	\$163.50	\$311.22	\$256.44
2-Party	\$212.58	\$479.34	\$322.32	\$615.00	\$506.76
Family	\$322.74	\$728.22	\$489.90	\$934.80	\$770.22

Annual Rates, Attained Age Under 50

Plan	IND100	IND200	IND300	IND400	IND500
Single	\$207.96	\$370.68	\$249.84	\$475.56	\$391.80
2-Party	\$410.28	\$732.36	\$492.48	\$939.72	\$774.36
Family	\$622.80	\$1,112.76	\$748.56	\$1,428.24	\$1,176.84

Annual Rates, Attained Age 50 or Greater

Plan	IND100	IND200	IND300	IND400	IND500
Single	\$207.96	\$468.12	\$315.48	\$600.72	\$495.00
2-Party	\$410.28	\$925.20	\$622.08	\$1,186.92	\$978.12
Family	\$622.80	\$1,405.56	\$945.48	\$1,804.20	\$1,486.56

SERFF Tracking Number: FRCS-126643128 State: Arkansas
 Filing Company: United Concordia Insurance Company State Tracking Number: 45832
 Company Tracking Number: 5199
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: Individual Dental Filing
 Project Name/Number: UCCI/64/64

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments:</p> <p>Attachments: AR Readability Certification.pdf AR Certificate of Compliance.pdf</p>	Approved-Closed	07/08/2010
<p>Satisfied - Item: Application</p> <p>Comments: Please see the forms schedule.</p>	Approved-Closed	07/08/2010
<p>Satisfied - Item: Outline of Coverage</p> <p>Comments: Please see the forms schedule.</p>	Approved-Closed	07/08/2010
<p>Satisfied - Item: Authorization</p> <p>Comments:</p> <p>Attachment: Auth_UCIC_4-10_dist.pdf</p>	Approved-Closed	07/08/2010

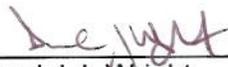
**STATE OF ARKANSAS
READABILITY CERTIFICATION**

COMPANY NAME: United Concordia Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
ARIN01-0310UCIC	50.8
INEL1-0309	51.2
INAPL-0309	*
INS-1-0309	*
INS-2-0309	*
INS-3-0309	*
INS-4-0309	*
INS-5-0309	*
INAPP-0309	*

*Scores a 50+ when combined with the policy.



Daniel J. Wright
Treasurer, Vice President and Controller

May 25, 2010
Date

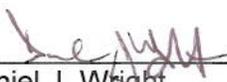
STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE

Company Name: United Concordia Insurance Company

Form Titles: Individual Dental Insurance Policy, Schedule of Exclusions and Limitations, Appeal Procedure Addendum, Outline of Coverage, Schedule of Benefits, Enrollment Form

Form Numbers: ARIN01-0310UCIC, INEL1-0309, INAPL-0309, ARINOC-0309UCIC
INS-1-0309, INS-2-0309, INS-3-0309, INS-4-0309, INS-5-0309, INAPP-0309

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Daniel J. Wright
Treasurer, Vice President and Controller

May 25, 2010

Date

UNITED CONCORDIA

April 20, 2010

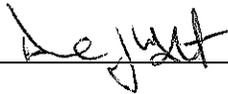
To: The Insurance Commissioner

Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

United Concordia Insurance Company

By: 

Title: Treasurer, Vice President and Controller

SERFF Tracking Number: *FRCS-126643128* State: *Arkansas*
 Filing Company: *United Concordia Insurance Company* State Tracking Number: *45832*
 Company Tracking Number: *5199*
 TOI: *H101 Individual Health - Dental* Sub-TOI: *H101.000 Health - Dental*
 Product Name: *Individual Dental Filing*
 Project Name/Number: *UCCI/64/64*

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/28/2010	Form	Enrollment Form	06/29/2010	individual_enrollment6 (2).pdf (Superseded)

UNITED CONCORDIA Application for Individual Dental Insurance

SECTION A: POLICYHOLDER'S INFORMATION			Requested Effective Date
Social Security Number		Phone Number	
Policyholder's Name (Last, First, Middle Initial, Suffix)		Date of Birth	Gender
Home Address		City	State
Email Address		Zip Code	

SECTION B: DEPENDENT INFORMATION						
Social Security Number	Type	Last Name	First Name	MI	Gender	Date of Birth
	Spouse/ Domestic Partner					
	Dependent (A)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (B)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (C)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Dependent (D)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>

Replacement of Coverage – Is this insurance intended to replace ANY current dental insurance? Yes No **If yes, complete the following:**

Insurance Company Name: _____ Policy Number: _____

SECTION C: GENERAL INFORMATION		
Premium Payment Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually	My Individual Dental Insurance will be covering: <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Self and one dependent <hr/> Premium Payment (\$):	Plan Selection: <input type="checkbox"/> IND 100 <input type="checkbox"/> IND 400 <input type="checkbox"/> IND 200 <input type="checkbox"/> IND 500 <input type="checkbox"/> IND 300

I represent that all information supplied in this application is true and correct. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

Policyholder's Signature _____ **Date** _____

SECTION D: PRODUCER / AGENCY / GENERAL AGENT (IF APPLICABLE)		
Producer Name		Social Security Number
United Concordia Producer ID Number	State	License Number
Signature		Date
Agency Name		Agency Tax ID Number
United Concordia Producer ID Number	State	License Number
General Agent Name		General Agent Tax ID Number
United Concordia Producer ID Number	State	License Number

APPLICABLE STATE MANDATED PROVISIONS

- | | |
|---|--|
| <p>CA: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.</p> <p>FL: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.</p> <p>KS: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.</p> <p>LA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p> <p>MD: Any person who knowingly presents a false or fraudulent claim form for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p> <p>NJ: All statements made by applicant are true and complete to the best of the applicant's knowledge and belief. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.</p> | <p>NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.</p> <p>OR: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.</p> <p>PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.</p> <p>TN: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.</p> <p>VA: Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.</p> <p>WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.</p> |
|---|--|

UNITED CONCORDIA OPERATES AS A WHOLLY OWNED SUBSIDIARY UNDER THE NAME LISTED BELOW IN THE FOLLOWING STATES:

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- United Concordia Insurance Company—AK, AR, AZ, CA, CO, CT, FL, GA, HI, IA, ID, IN, KS, LA, MA, ME, MI, MN, MS, MT, NE, NH, NV, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WV, WY
- United Concordia Life and Health Insurance Company—DE, DC, IL, KY, MD, MO, NC, NJ, PA
- United Concordia Insurance Company of New York—NY