

SERFF Tracking Number: UCIN-128131350 State: Arkansas
 Filing Company: United Concordia Insurance Company State Tracking Number:
 Company Tracking Number: AR/UCIC/005-12
 TOI: H10I Individual Health - Dental Sub-TOI: H10I.000 Health - Dental
 Product Name: iDental 2012
 Project Name/Number: iDental Variability, Child-Only, HCR/AR/UCIC/005-12

Filing at a Glance

Company: United Concordia Insurance Company

Product Name: iDental 2012

SERFF Tr Num: UCIN-128131350 State: Arkansas

TOI: H10I Individual Health - Dental

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

Sub-TOI: H10I.000 Health - Dental

Co Tr Num: AR/UCIC/005-12 State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Authors: Benjamin Schaefer, Krista Disposition Date: 04/02/2012

Maddigan, Kathleen McGonigle,

Stacy Miller, Jennifer Bayich, Bob

Hackman, Rob Frew

Date Submitted: 03/30/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: iDental Variability, Child-Only, HCR

Status of Filing in Domicile: Pending

Project Number: AR/UCIC/005-12

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Arizona is the state
of domicile and a similar filing is pending there.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 04/02/2012

State Status Changed: 04/02/2012

Deemer Date:

Created By: Krista Maddigan

Submitted By: Jennifer Bayich

Corresponding Filing Tracking Number:

Filing Description:

United Concordia Insurance Company ("Company"), NAIC number 85766, which currently offers both individual and group dental insurance, is submitting this filing for approval. The filing contains the following new and revised forms for use in the individual dental insurance market.

Form Name

Form Number Prior Form Number Prior SERFF # Prior Approval Date

Individual Dental Policy

ARIN01-0312UCIC

ARIN01-0310UCIC

FRCS-126643128

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07/08/2010

Schedule of Benefits	INS-VAR-0312 N/A	N/A	N/A
Outline of Coverage	ARINOC-0312UCIC	ARINOC-0309 FRCS-126643128	07/08/2010
Application	INAPP-0312	ARINAPP-0311 UCIN-127062610	03/18/2011
Limiting Age Endorsement	INAgeVar 0312	N/A	N/A N/A
Effect of Termination Endorsement	INVOL/FraudLock 0312	N/A	N/A N/A
Effect of Termination Endorsement	INFraudLock 0312	N/A	N/A N/A
Effect of Termination Endorsement	INRemoveLock 0312	N/A	N/A N/A

The Individual Dental Policy has been revised for several purposes. First, it has been revised to accommodate different types of policyholders, those who may wish to provide coverage for themselves and any dependents under a traditional family policy and those wishing to provide coverage solely for dependents. Previous versions of the policy only permitted enrollment under a traditional family policy. Second, the policy has been revised to enable the Company to continue offering it both within and outside the individual insurance exchanges that will be established in response to the federal Patient Protection and Affordable Care Act (“the Act”). References found in the policy to “applicable law and regulation,” and to an “authorized private or government entity” are intended to address the anticipated evolution of laws and regulations related to state and regional individual insurance exchanges and the Act. Please note that a Statement of Variability is not included for the Policy since variability is limited to the Company’s addresses, website and phone numbers, and on the Policy Schedule, the policyholder name, date of birth, effective date, billing frequency, type of coverage, premium rates, dental product selected, and enrollment and service fees.

The new Schedule of Benefits introduces variability that will be necessary to establish a competitive position for the Company in anticipation of rapid individual market evolution. It will provide the flexibility necessary to continue offering the plan designs previously approved by the Department and to develop new plans as necessary to compete both within and outside individual insurance exchanges that will be established in response to the Act. These Schedules were previously approved by the Department under SERFF Tracking IDs FRCS-126643128 and UCIN-127062610. The PDF pipelines evidencing the approvals are attached for your reference under the Supporting Documents Tab. It is expected that market demands and the evolving regulatory arena will require new plan offerings, and having a variable schedule will enhance the Company’s speed to market. A Statement of Variability has been included to explain the variability included in the new Schedule of Benefits.

The attached Outline of Coverage, (form number ARINOC-0312UCIC), replaces the prior Outline of Coverage (form number ARINOC-0309UCIC). It has been revised to eliminate references to classes of service, instead listing the specific benefit categories that may be covered by the plan. Terminology used in the form has also been updated to coincide with changes in defined policy terms.

The Application (form number INAPP-0312) replaces the prior Application (form # ARINAPP-0311) for Dental Insurance. It has been revised to permit its use for either a traditional family policy covering an individual adult with or without

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members of his/her family, or for a policy covering only a child or children.

The Limiting Age Endorsement (form # INAgeVar 0312) is a new form to be used with policies covering only children. The Endorsement increases the limiting age from age 18 to an age between 19 and 26. The variability in the extension of the limiting age is intended to permit the Company to respond to mandated age limits for pediatric benefits that will be established by the state or by an individual insurance exchange. These endorsements will not be individually selectable by the policyholder, but rather, will be implemented consistently across all similarly situated applicants for the policy. Please note that a Statement of Variability is not included for the Limiting Age Endorsement since variability is limited to the age at which the policy terminates – 19, 20, 21, 22, 23, 24, 25, or 26.

Three new forms entitled, “Effect of Termination Endorsement” are included. These permit the Company to implement different provisions depending on operational strategy or regulatory requirements. Form number INVol/FraudLock 0312 only applies the “lock-out period” to policyholders terminating a child-only policy when fraud, misrepresentation or non-payment is the cause of termination. For policyholders terminating a traditional family policy, the “lock-out” period applies for voluntary termination, in addition to fraud, misrepresentation or non-payment. Form number INFraudLock 0312 eliminates the “lock-out period” when the termination is voluntary, applying it only when the termination is related to fraud, misrepresentation or non-payment of premium. Form number INRemoveLock 0312 eliminates the “lock-out period” altogether. These endorsements will not be individually selectable by the policyholder, but rather, will be implemented consistently across all similarly situated applicants for the policy.

Several forms that were previously approved by the Department are not being altered. These will continue to be used with the new policy form and related forms. These are attached for your convenience under Supporting Documentation and are listed for your reference below:

Form Name	Form Number SERFF #		Approval
Appeal Procedure Addendum	INAPL-0309	FRCS-126643128	07/08/2010
Schedule of Exclusions and Limitations	INEL1-0309	FRCS-126643128	
07/08/2010			
Schedule of Benefits	INS-1-0309	FRCS-126643128	07/08/2010
Schedule of Benefits	INS-2-0309	FRCS-126643128	07/08/2010
Schedule of Benefits	INS-3-0309	FRCS-126643128	07/08/2010
Schedule of Benefits	INS-4-0309	FRCS-126643128	07/08/2010
Schedule of Benefits	INS-5-0309	FRCS-126643128	07/08/2010
Schedule of Benefits	INS-1-0311	UCIN-127062610	03/18/2011
Schedule of Benefits	INS-2-0311	UCIN-127062610	03/18/2011
Schedule of Benefits	INS-3-0311	UCIN-127062610	03/18/2011
Schedule of Benefits	INS-4-0311	UCIN-127062610	03/18/2011
Schedule of Benefits	INS-5-0311	UCIN-127062610	03/18/2011

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The above referenced Schedules are no longer being actively marketed, but rather maintained in the market place for those already enrolled. Again the PDF pipelines evidencing their prior approval are attached for your reference. Also provided, are the previously approved Appeals Procedure Addendum and the Exclusions and Limitations Addendum.

The rate manual enclosed with this filing addresses plan designs previously approved by the Department as reference in the chart above, as well as plan designs that may be introduced using the variable Schedule of Benefits, (form number INS-VAR-0312), which is attached as part of this filing. The variability introduced in Schedule of Benefits and the enclosed rate manual is necessary to establish a competitive position for the Company in anticipation of rapid individual market evolution. They will provide the flexibility necessary to compete both within and outside individual insurance exchanges established in response to the federal Patient Protection and Affordable Care Act and to adapt to market demands and the evolving regulatory arena. The attached rate manual also accommodates different types of policyholders, those who may wish to provide coverage for themselves and any dependents under a traditional family policy and those wishing to provide coverage solely for dependents. Previous rating methodology contemplated only traditional family policies.

Thank you for your attention to this filing. If you should have any questions or require additional information I may be reached at 412-544-0923 or via email to Jennifer.bayich@highmark.com.

Sincerely,
Jennifer L. Bayich, Esq.
Regulatory Compliance Consultant.
State Narrative:

Company and Contact

Filing Contact Information

Jennifer Bayich, Regulatory Compliance Consultant
501 Penn Avenue
PAP6415
Pittsburgh, PA 15222
jennifer.bayich@highmark.com
412-544-0923 [Phone]

Filing Company Information

United Concordia Insurance Company
4401 Deer Path Road
Harrisburg, PA 17110
(800) 929-0538 ext. 57225[Phone]
CoCode: 85766
Group Code: 812
Group Name: Highmark
FEIN Number: 86-0307623
State of Domicile: Arizona
Company Type: LAH
State ID Number:

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Filing Fees

Fee Required? Yes
Fee Amount: \$400.00
Retaliatory? No
Fee Explanation: 7 forms x\$50 & 1 Rate Filing x\$50 = \$400
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Concordia Insurance Company	\$400.00	03/30/2012	57593660

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/02/2012	04/02/2012

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Disposition

Disposition Date: 04/02/2012

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	0.000%	6.900%	\$2,562	29	\$37,131	7.500%	6.000%

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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	Statement of Variables	Approved-Closed	Yes
Supporting Document	PDF Pipeline of Previously Approved Schedules 00 Series	Approved-Closed	Yes
Supporting Document	PDF Pipeline of Previously Approved Schedules 01 Series	Approved-Closed	Yes
Supporting Document	Previously Approved Appeals Addendum	Approved-Closed	Yes
Supporting Document	Previously Approved Exclusions and Limitations	Approved-Closed	Yes
Supporting Document	Red-Lined Documents	Approved-Closed	Yes
Supporting Document	Rate Calculation Example	Approved-Closed	No
Form	Policy	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Rate	Rate Manual	Approved-Closed	Yes

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Form Schedule

Lead Form Number: tbd

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/02/2012	ARIN01-0312UCIC	Policy/Cont ract/Fraternal Certificate	Policy	Initial		51.900	AR iDental Policy 0312CLEAN.pdf
Approved-Closed 04/02/2012	INS-VAR-0312	Schedule Pages	Schedule of Benefits	Initial			Master Schedule of Benefits 0312.pdf
Approved-Closed 04/02/2012	INAPP-0312	Application/ Enrollment Form	Application	Initial			Master iDental application FINAL 0312.pdf
Approved-Closed 04/02/2012	INAgeVar 0312	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Endorsement	Initial		59.300	Master Limiting Age Endorsement _variable_ 0312.pdf
Approved-Closed 04/02/2012	INVol/FraudLock 0312	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Endorsement	Initial		45.900	Master Lockout _vol&fraud_ Endorsement 0312.pdf
Approved-Closed 04/02/2012	INFraudLock 0312	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Endorsement	Initial		47.200	Master Lockout _fraud_ Endorsement 0312.pdf

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<i>Company Tracking Number:</i>	<i>AR/UCIC/005-12</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>iDental 2012</i>				
<i>Project Name/Number:</i>	<i>iDental Variability, Child-Only, HCR/AR/UCIC/005-12</i>				
Approved- INRemoveL	Certificate	Endorsement	Initial	47.500	Master
Closed	ock 0312	Amendmen			Lockout
04/02/2012	t, Insert	Page,			Removal
	Endorseme	nt or Rider			Endorsement
					0312.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 those Insured Persons enrolled by the Policyholder 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.

F. G. King (Marked)

Company Officer

D. J. King

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
- Endorsement(s), if applicable

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.

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.

Contract Year – The period of twelve (12) months beginning on the Effective Date or the anniversary of the Effective Date and ending on the day before the Renewal Date.

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(s) – 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.

Family Policy – A Policy that covers the Policyholder and may also cover eligible Dependents, as defined in the Eligibility and Effective Date section. A Policy that covers only a child or only children is not a Family 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(s) - The greatest amount the Policy will allow for a specific service.

Insured Person(s) - Individuals enrolled under the Policyholder's plan. Also referred to as "You," "Your" or "Yourself."

Non-Participating Dentist(s) - A Dentist who has not contracted with Us to limit his/her charges to Insured Persons.

Out-of-Pocket Expense(s) – Costs not paid by Us, including but not limited to Coinsurance, Deductibles, amounts billed by Non-Participating Dentists that are over the Maximum Allowable Charge, costs of services that exceed the Policies Limitations or Maximums, or for services that are Exclusions. The Insured Person is responsible to pay for Out-of-Pocket Expenses.

Participating Dentist(s) - A Dentist who has executed a Participating Dentist agreement with Us, under which he/she agrees to accept Maximum Allowable Charges as payment in full for Covered Services. Participating Dentists may also agree to limit their charges for any other services delivered to Insured Persons.

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. In the case of a policy covering only a child or only children, the Policyholder is the child/children's parent, legal guardian or legal custodian.

Premium - Payment that must be remitted in exchange for coverage of Insured Persons.

Renewal Date - The date the Policy renews.

Schedule of Benefits - Attached summary of Covered Services, Policy payments, 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.

Spouse – The Policyholder's partner by marriage or by any union between two adults that is recognized by law in the state where this Policy is issued.

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.

We, Our or Us - The Company, its affiliate or an organization with which it contracts for a provider network and/or to perform certain functions to administer this Policy.

ELIGIBILITY AND EFFECTIVE DATE

In order to become insured, You must meet the eligibility requirements of this Policy and any additional eligibility requirements that may be imposed by law or regulation, We must receive information about the Policyholder, Insured Persons, the selected dental product, payment method, and billing frequency. Coverage will begin on the first day of the month following receipt of enrollment or on any such date as may be specified in the enrollment information We receive from an authorized private or government entity. We reserve the right to require proof of dependency. An identification (ID) card will be provided indicating Your Policy number.

When a Policy covering only a child or only children is purchased, the Policyholder's natural children, adoptive children or children under the legal custody of or placed with the Policyholder by a court or administrative agency are eligible as Insured Persons up to the "Limiting Age" of eighteen (18). Dependents, defined below, are not eligible for coverage under a child-only Policy. Each child can be covered under only one (1) Policy issued by Us, either a child-only Policy or a Family Policy, at the Policyholder's option. If a child is enrolled in more than one (1) Policy issued by Us, the Policyholder must select the Policy from which to terminate the child's coverage and any unearned Premium for that Policy will be returned to the Policyholder.

"Dependents" eligible for coverage in a Family Policy include:

1. The Policyholder's Spouse or domestic partner as defined by any applicable state law; and
2. Any natural child, stepchild, 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 twenty-six (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 the Effective Date of a Family Policy, the Policyholder may add Dependents if they meet the requirements detailed above and the required change information is provided to Us. The Policyholder may also add or remove Dependents or change benefit plans during the timeframes specified by applicable law or regulation. 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 or on the date dictated by applicable law or regulation. Future bills 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 in a Family Policy 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 in a Family Policy 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. In Policies that cover only a child or only children, newborns of Insured Persons are not eligible for coverage.

For Family Policies, coverage will end at 12:00 midnight the last day of the month during which one of the following occurs, or on the date dictated by applicable law or regulation:

1. for a Dependent Spouse, We receive notice that the Policyholder becomes legally divorced or that the union is legally dissolved.
2. for a domestic partner, We receive a request from the Policyholder to discontinue coverage.
3. for Dependent children, they no longer meet the requirements detailed above.

For a Policy that covers only a child or only children, coverage will end on the last day of the Contract Year during which the child reaches the Limiting Age specified above unless terminated earlier as specified under the Policy Termination section or unless a different termination date is specified by an authorized private or governmental entity or by applicable law or regulation. For children reaching the Limiting Age, We will notify You in advance that You have a conversion period after Your Termination Date to convert to a Family Policy. If You convert to a Family Policy during the conversion period, any applicable Waiting Periods in the Family Policy will be credited for the time that You were insured under the prior Policy, and You will not have a lapse in coverage. After the conversion period expires, You must re-enroll in a Family Policy and the full Waiting Period will apply before You are eligible for benefits.

Notification of divorce, legal dissolution of the union with a Spouse 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 the next bill.

For an enrolled Dependent child who is mentally or physically handicapped, evidence of his/her reliance on the Policyholder or the Policyholder's Spouse for maintenance and support due to the child's condition must be supplied within sixty (60) days of Our request. Such evidence must include information provided by the Insured Person's physician and will be requested no more frequently than annually.

CONVERSION FOR DEPENDENTS

When a Spouse or child loses eligibility or is terminated for another reason from a Family Policy, the former Spouse or child must re-apply for coverage. Waiting Periods will apply before You are eligible for benefits under the new Policy.

If this Policy covers only one Insured Person 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 that a Family Policy covers Dependents or the Policy covers only a child/children at the time of the Policyholder's death, the Policyholder's enrolled surviving Spouse or, if no Spouse is enrolled, an enrolled child of legal contracting age 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 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. Premiums will be based on the rates in effect on the Policy's Renewal Date. The Company will make no change in 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 thirty-one (31) days will be granted for payment of the overdue Premium unless a longer Grace Period is required by law or regulation. 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. The Grace Period will not apply if, at least thirty (30) days before the due date, We have delivered or mailed to the Policyholder's last known address written notice of Our intent not to renew this Policy.

Reinstatement: If any Premium is not paid within the Grace Period specified above, 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 forty-fifth (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 sixty (60) days prior to the date of reinstatement.

Misstatement of Age: If the age of any 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 sixty (60) days advance notice of any change in Premium at renewal.
2. The Policyholder may elect to terminate the Policy on the Renewal Date or on any other date permitted by applicable law or regulation.
3. The Policyholder may change dental products at renewal and during the timeframes specified by applicable law or regulation. Replacement Schedules of Benefits and Exclusions and Limitations depicting the product choice will be supplied. Any applicable Waiting Periods in the new plan selected will be credited for the amount of time that You have been enrolled in the Policy.. Any change in Premium will be included on the next bill.
4. We may elect not to renew the Policy with sixty (60) days advance notice if any of the following occur:

- a) Fraud or material misrepresentation by or with the knowledge of the Policyholder or an Insured Person applying for this coverage or filing a claim for benefits;
- b) The Policyholder or an Insured Person 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

Policy Termination Reasons: 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. The Policyholder may voluntarily 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 the written notice unless a different termination date is required by law or regulation, or 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 Premium was paid.
3. We may decline to renew the Policy as provided by Provision 4 of the above renewal clause.
4. This Policy will terminate if it covers only one (1) Insured Person and he/she dies.
5. This Policy will terminate if it covers only one (1) Insured Person and an authorized private or government entity notifies Us that he/she is no longer eligible for coverage.

Effect of Termination: For a Family Policy, the Policyholder will not be permitted to re-enroll himself/herself for three (3) years (the “Lock-out Period”) from the Termination Date if the Policyholder voluntarily terminates the Policy at renewal_or on any other date, or if the Policy is terminated for fraud, material misrepresentation, or non-payment of Premium. Lock-out Periods do not apply to Policies covering only a child or only children.

If the Policyholder voluntarily terminates a Family Policy in order to apply for a Policy covering only a child or only children, the Policyholder must submit a new application for the child/children’s coverage. Benefits under the new child-only or children-only Policy will be paid after any applicable Waiting Periods and/or Deductibles are met.

The Lock-out Period does not apply if the Policyholder voluntarily terminates a Policy covering only a child or only children and submits a new application for a Family Policy. Benefits under the new Family Policy will be paid after any applicable Waiting Periods and/or Deductibles are met.

Benefits After Coverage Terminates: We are not liable to pay any benefits for services which are started after the Insured Person’s Termination Date. However, coverage for completion of a dental procedure requiring two (2) or more visits on separate days will be extended for a period of ninety (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

Insured Persons may choose any licensed Dentist for services. However, choosing a Participating Dentist, may limit Out-of-Pocket Expenses. Participating Dentists limit their fees to their contracted Maximum Allowable Charges for

Covered Services. Also, if agreed by the provider, Participating Dentists limit their charges for all services delivered to Insured Persons, even if the service is not covered for any reason and a benefit is not paid under this Policy. 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.

When using a Non-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 Expenses.

Covered Services

Benefits and any applicable Deductibles, Maximums and Waiting Periods are shown on the attached Schedule of Benefits.

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

When treatments are performed by a Participating Dentist, We will pay covered benefits directly to the Participating Dentist. Both You and the Dentist will be notified of benefits covered, Our payment and any Out-of-Pocket Expenses. 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 Us 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.

When treatments are performed by a Non-Participating Dentist, We will send payment for Covered Services to You unless the claim indicates that payment should to be sent directly to the treating Dentist. This is called assignment of benefits, and it is available for care delivered by Non-Participating Dentists outside of Pennsylvania and West Virginia. You will still be notified of the services covered, Our payment and any Out-of-Pocket Expenses. 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.

Value-Added Programs and Services

From time to time, We offer Insured Persons access to various lifestyle, health and/or value-added programs and services. Such offerings are subject to change at any time without notice. Contact your agent or call Customer Service

for eligibility requirements and other information. Eligibility requirements for these programs and services are applied in a uniform, non-discriminatory manner to all Insured Persons.

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

Upon receipt of a notice of claim, We will furnish to the Insured Person such forms as are usually furnished by Us for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after We 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 Us at Our said office within ninety (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.

Our acknowledgment 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 The Company's 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

The Company 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 the Policyholder lives 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 sixty (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}	{\$ XX.XX}
	{Policyholder and One Dependent}	{\$ XX.XX}
	{Family}	{\$XXX.XX}
	{Child Only}	{\$XX.XX}
	{Children Only}	{\$XX.XX}
<i>Dental Product Selected:</i>	Plan {XXXXXXX }	
<i>{Enrollment Fee:}</i>	{XXX}	
<i>{Service Fee (applied on each Premium invoice):}</i>	{XXX}	

Schedule of Benefits

This Policy will pay benefits for Covered Services shown below subject to the Schedule of Exclusions and Limitations and other Policy terms. Payment is based on the Maximum Allowable Charge (MAC) for the specific Covered Service. Participating Dentists accept contracted MACs as payment in full for services. Non-participating Dentists do not limit their charges and may bill You for the difference between their charge and the benefit paid by the Policy.

Contract Year Deductible per Insured Person:	{None; \$25; \$50; \$75; \$100}
Contract Year Maximum per Insured Person:	{Unlimited; {\$500; \$750; \$1,000; \$1,200; \$1,250; \$1,500; \$1,750; \$2,000; \$2,500; \$3,000; \$3,500; \$4,000; \$4,500; \$5,000} }
Orthodontic Lifetime Maximum per Insured Person:	{Not Covered; \$500; \$1,000; \$1,500; \$2,000}

Service Category	Waiting Period	Policy Pays at		After Deductible
		Participating Dentists	Non-Participating Dentists	
Oral Evaluations (Exams)	{None; N/A}	{Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Yes; No; N/A}
Radiographs (All X-Rays)	{None; N/A}	{Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Yes; No; N/A}
Prophylaxis (Cleanings)	{None; N/A}	Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Yes; No; N/A}
Fluoride Treatments	{None; N/A}	{Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Yes; No; N/A}
Palliative Treatment (Emergency)	{None; N/A}	{Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Yes; No; N/A}
Sealants	{None; {3; 6} months; N/A}	{Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Yes; No; N/A}
Other Diagnostic & Preventive Services	{None; {3; 6} months; N/A}	{Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Yes; No; N/A}
Space Maintainers	{None; {3; 6} months; N/A}	{Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Yes; No; N/A}
Amalgam Restorations (Metal fillings)	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Yes; No; N/A}

Resin-based Composite Restorations (White fillings)	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A}
Crowns, Inlays, Onlays	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A}
Crown Repair	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A}
Endodontic Therapy (Root canals, etc.)	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A}
Other Endodontic Services	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A}
Surgical Periodontics	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A}
Non-Surgical Periodontics	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A}
Periodontal Maintenance	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A}
Prosthetics (Complete or Fixed Partial Dentures)	{None;	{Not Covered; 20%;	{Not Covered; 20%;	{ Yes; No;

	{3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	N/A}
Adjustments and Repairs of Prosthetics	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A}
Other Prosthetic Services	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A}
Implant Services	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A}
Simple Extractions	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A}
Surgical Extractions	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A}
Oral Surgery	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A}
General Anesthesia, Nitrous Oxide and/or IV Sedation	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A}
Consultations	{None; {3; 6; 9;	{Not Covered; 20%; 25%; 30%; 35%; 40%;	{Not Covered; 20%; 25%; 30%; 35%; 40%;	{ Yes; No; N/A}

	12; 15; 18; 21; 24} months; N/A}	45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	
Adjunctive General Services	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	{ Yes; No; N/A }
Orthodontics (up to age 19)	{None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	{Not Covered; 10%; 20%; 30%; 40%; 50%; 60%; 70%; 80%; 90%; 100% }	{Not Covered; 10%; 20%; 30%; 40%; 50%; 60%; 70%; 80%; 90%; 100% }	{ Yes; No; N/A }

SECTION A: POLICYHOLDER'S INFORMATION (PURCHASER)						Requested Effective Date
Policyholder's Name (Last, First, Middle Initial, Suffix)				Phone Number		
Email Address			Date of Birth		Relationship (If Child/Children Only Policy)	
Billing Address			City		State	Zip Code
Mailing Address			City		State	Zip Code
SECTION B: INSURED INFORMATION (INDIVIDUALS TO BE COVERED)						
Social Security Number	Type	Last Name	First Name	MI	Gender	Date of Birth
	Insured					
	Insured Spouse/ Domestic Partner					
	Insured Child (A)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Insured Child (B)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Insured Child (C)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Insured Child (D)					Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
SECTION C: GENERAL INFORMATION						
Premium Payment Frequency:		My Individual Dental Insurance will be covering:			Plan Selection:	
<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually		<input type="checkbox"/> Policyholder only <input type="checkbox"/> Policyholder and One Dependent <input type="checkbox"/> Family <input type="checkbox"/> Child only <input type="checkbox"/> Children only			_____ _____	
Premium Payment (\$):						
Replacement of Coverage – Is this insurance intended to replace ANY current dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following: Insurance Company Name: _____ Policy Number: _____						

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 & RI: 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.

KY: 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.

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

UNITED CONCORDIA®

LIMITING AGE ENDORSEMENT
TO
INDIVIDUAL DENTAL INSURANCE POLICY

This Endorsement is effective on the Effective Date as stated in the Policy and attached to and made part of the Policy.

The following replaces the second (2nd) paragraph in the section “ELIGIBILITY AND EFFECTIVE DATE” of the Individual Dental Policy:

When a Policy covering only a child or only children is purchased, the Policyholder’s natural children, adoptive children or children under the legal custody of or placed with the Policyholder by a court or administrative agency are eligible as Insured Persons up to the “Limiting Age” of {nineteen (19); twenty (20); twenty-one (21); twenty-two (22); twenty-three (23); twenty-four (24); twenty-five (25); twenty-six (26)}. Dependents, defined below, are not eligible for coverage under a child-only Policy. Each child can be covered under only one (1) Policy issued by Us, either a child-only Policy or a Family Policy, at the Policyholder’s option. If a child is enrolled in more than one (1) Policy issued by Us, the Policyholder must select the Policy from which to terminate the child’s coverage and any unearned Premium for that Policy will be returned to the Policyholder.

**EFFECT OF TERMINATION ENDORSEMENT
TO
INDIVIDUAL DENTAL INSURANCE POLICY**

This Endorsement is effective on the Effective Date as stated in the Policy and attached to and made part of the Policy.

The following replaces the “Effect of Termination” subsection within in the “POLICY TERMINATION” section of the Individual Dental Policy:

Effect of Termination: The Policyholder will not be permitted to re-enroll himself/herself for three (3) years (the “Lock-out Period”) from the Termination Date under the following circumstances:

1. For a Family Policy, the Policyholder voluntarily terminates the Policy at renewal or on any other date, or the Policy is terminated for fraud, material misrepresentation, or non-payment of Premium,
2. For a Policy covering only a child or only children, the Policy is terminated for fraud, material misrepresentation, or non-payment of Premium.

If the Policyholder voluntarily terminates a Family Policy in order to apply for a Policy covering only a child or only children, the Policyholder must submit a new application for the child/children’s coverage. Benefits under the new child-only or children-only Policy will be paid after any applicable Waiting Periods and/or Deductibles are met.

The Lock-out Period does not apply if the Policyholder voluntarily terminates a Policy covering only a child or only children and submits a new application for a Family Policy. Benefits under the new Family Policy will be paid after any applicable Waiting Periods and/or Deductibles are met.

**EFFECT OF TERMINATION ENDORSEMENT
TO
INDIVIDUAL DENTAL INSURANCE POLICY**

This Endorsement is effective on the Effective Date as stated in the Policy and attached to and made part of the Policy.

The following replaces the “Effect of Termination” subsection within in the “POLICY TERMINATION” section of the Individual Dental Policy:

Effect of Termination: The Policyholder will not be permitted to re-enroll himself/herself for three (3) years (the “Lock-out Period”) from the Termination Date if the Policy is terminated for fraud, material misrepresentation, or non-payment of Premium.

If the Policyholder voluntarily terminates a Family Policy in order to apply for a Policy covering only a child or only children, the Policyholder must submit a new application for the child/children’s coverage. Benefits under the new child-only or children-only Policy will be paid after any applicable Waiting Periods and/or Deductibles are met.

The Lock-out Period does not apply if the Policyholder voluntarily terminates a Policy covering only a child or only children and submits a new application for a Family Policy. Benefits under the new Family Policy will be paid after any applicable Waiting Periods and/or Deductibles are met.

**EFFECT OF TERMINATION ENDORSEMENT
TO
INDIVIDUAL DENTAL INSURANCE POLICY**

This Endorsement is effective on the Effective Date as stated in the Policy and attached to and made part of the Policy.

The following replaces the “Effect of Termination” subsection within in the “POLICY TERMINATION” section of the Individual Dental Policy:

Effect of Termination: If the Policyholder voluntarily terminates a Family Policy in order to apply for a Policy covering only a child or only children, or if the Policyholder voluntarily terminates a Policy covering only a child or only children in order to apply for a Family Policy, the Policyholder must submit a new application for coverage. Benefits under the new Policy will be paid after any applicable Waiting Periods and/or Deductibles are met.

SERFF Tracking Number: UCIN-128131350 State: Arkansas
 Filing Company: United Concordia Insurance Company State Tracking Number:
 Company Tracking Number: AR/UCIC/005-12
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: iDental 2012
 Project Name/Number: iDental Variability, Child-Only, HCR/AR/UCIC/005-12

Rate Information

Rate data applies to filing.

Filing Method: SERFF
Rate Change Type: Increase
Overall Percentage of Last Rate Revision: 0.000%
Effective Date of Last Rate Revision:
Filing Method of Last Filing: SERFF

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	0.000%	6.900%	\$2,562	29	\$37,131	7.500%	6.000%

SERFF Tracking Number: UCIN-128131350 State: Arkansas
 Filing Company: United Concordia Insurance Company State Tracking Number:
 Company Tracking Number: AR/UCIC/005-12
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: iDental 2012
 Project Name/Number: iDental Variability, Child-Only, HCR/AR/UCIC/005-12

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 04/02/2012	Rate Manual	ARIN01-0312UCIC, INS-VAR-0312	New		AR Rate Manual.pdf

United Concordia
Insurance Company

Arkansas

Individual Dental
Rating Manual

Individual Rating Manual

I. Introduction

A. Purpose

This manual documents United Concordia 's rating methodology for determining rates for fee-for-service individual dental insurance.

This rate manual:

- 1) Describes the rating methods used and the purpose of each.
- 2) Provides an overview of the manual-rating algorithm.
- 3) Contains tables of pricing factors for each of the rating steps..

B. Overview of the Manual Rating Algorithm

Part II of this manual outlines the steps of the rating algorithm for adult contracts.

C. Appendices

Appendix A shows tables of factors used in calculations in the corresponding steps of the rating algorithm.

Appendix B shows differences in the rating algorithm when applicable state law or regulation defines pediatric coverage, in which case the contract holder may be a child.

Individual Rating Manual

II Manual Rating Algorithm – Adult Contracts

A. Development of Claim Costs for Adult Contracts

Note: Table number corresponds to step number. For example, Step 1 refers to values in Table 1.

1) Obtain Starting Claim Costs and Frequency for Chosen Plan

Claim costs from Table 1a are multiplied by corresponding factors from table 1b and the results are summed by class.

Table 1a lists average claim costs and frequency by benefit category for each class of coverage. These are separated into classes A, B and C for purposes of calculation.

Table 1b shows waiting period factors.

2) Deductible Credit Calculation

The impact of the deductible is calculated and applied.

a) Total Deductible Credit

The total credit from Table 2a is multiplied by a reduction factor which reflects level of covered services to which the deductible will apply. The sum of these services expressed as services per thousand members per year is divided by 1341.444 and the square root of the result is applied to the total credit.

b) Family Deductible Limit

A factor is applied which reflects the impact of the family deductible. This factor is calculated as:

$$(1 - X) \times (1 - \{\text{factor from Table 2b}\})$$

Where:

$$X = 0.18812 + (0.81188 \times \text{The Greater of } \{0, Y - 3\}) / (\text{Standard Class A Costs pmpm} - 3)$$

Standard Class A costs pmpm = \$148.17

Y = Class A pmpm's to which the deductible applies

Individual Rating Manual

c) Deductible Class Allocation

The allocation of the total deductible credit to each class is calculated as follows:

Factors FactA and FactB are determined from Table 2c

SumSvcA = total services in Class A to which the deductible applies

SumSvcB = total services in Class B to which the deductible applies

SumSvcC = total services in Class C to which the deductible applies

SumSvcTot = SumSvcA + SumSvcB + SumSvcC

AdjSvcA = SumSvcA

AdjSvcB = SumSvcB x 1.75

AdjSvcC = SumSvcC x 2.50

AdjSvcTot = AdjSvcA + AdjSvcB + AdjSvcC

EffSvcA = FactA x lesser of { AdjSvcA, EffSvcTot }

EffSvcB = Lesser of { (FactB x EffSvcTot), (EffSvcTot – EffSvcA) }

EffSvcC = Greater of { 0, lesser of
[(AdjSvcC), (EffSvcTot – EffSvcA – EffSvcB)] }

EffSvcTot = AdjSvcTot x 0.597288

Class Allocation A = EffSvcA / EffSvcTot

Class Allocation B = EffSvcB / EffSvcTot

Class Allocation C = EffSvcC / EffSvcTot

d) Adjusted Deductible Credit

Final Credit for each Class = (2a) x (2b) x (2c)

3) Apply Deductible Disincentive Factor

The factors in Table 3 reflect the impact of the deductible on total utilization

4) Adjusted Claim Cost

Adjusted Claim Cost = { (1) – (2d) } x (3)

5) Area Factor

Select factor from Table 5.

Individual Rating Manual

6) Coinsurance Adjustment

Determined for each category, summed by class for ease of computation.

7) Sub-total

Sub-total = (4) x (5) x (6)

8) Anti=Selection Adjustment

Select factor from Table 8.

9) Adjusted Claim Cost

Adjusted Claim Cost = (7) x (8)

10) Trend Adjustment

Starting claim costs and frequency assumptions are based on the time period January 1, 2010 to December 31, 2010. The Adjusted Claim Cost is multiplied by a trend adjustment reflecting the proposed benefit period of July 1, 2012 to June 30, 2013.

11) Annual Maximum Adjustment

The Annual Maximum Adjustment is calculated as follows:

MaxFact is determined from Table 10.

AdjMaxFact = 1 – MaxFact

SumCost = The sum of covered costs PMPM

CalcMaxFact = SumCost x (AdjMaxFact / 436.48)

Final Factor = 1 – CalcMaxFact

Individual Rating Manual

12) Total Non-Ortho PMPM Claim Cost

Total Non-Ortho PMPM Claim Cost = (9) x (10) x (11)

13) Tier Factors

The following tier factors are used to convert the Non-Ortho PMPM Claim Cost to the appropriate rating tiers:

Employee	1.000
Employee + 1 Dependent	1.975
Employee + 2 Dependents	3.000

14) Projected Dental Cost With Ortho

Projected Dental Cost is the product of the Total Non-Ortho PMPM Claim Cost and the Tier Factors, plus the cost of adult and/or child orthodontic coverage, if any. Orthodontic coverage is calculated as follows:

MaxBen = Maximum Benefit determined from the benefit plan.

ContFact = Continuation Factor determined from Table 14

Child Claim Cost = $2.554 \times \text{ContFact} \times \text{MaxBen} / 1000$

Adult Claim Cost = $0.398 \times \text{ContFact} \times \text{MaxBen} / 1000$

Claim Costs are multiplied by the appropriate tier factor:

	Adult	Child
Employee	1.0000	0.0000
Employee + 1 Dependent	1.8485	0.1515
Employee + 2 Dependents	1.9000	1.6418

15) Uniage Premium

The Projected Dental Cost With Ortho is divided by the Target Loss Ratio to determine Uniage Premium. Target Loss Ratio is discussed in the attached Actuarial Memorandum.

Individual Rating Manual

16) Premium By Age Band

Uniage Premium is converted to Premium By Age Band using the following Age and Modal Factors:

Age Under 50	0.95
Age 50 or More	1.20

Modal factors are used to produce rates other than monthly billing:

Monthly	1.000
Quarterly	2.913
Semi-Annual	5.660
Annual	10.919

17) Administrative Fees

The following fees may be added to the Premium by Age Band:

a) Enrollment Fee

A fee of no more than \$50 may be charged at the time of enrollment to supplement installation charges.

b) Service Fee

A monthly fee of no more than \$10 may be charged by billing cycle to supplement fees associated with the processing of a credit card, EFT transaction, or paper check.

Appendix A (Tables)

Table 1a: Starting Claim Costs PMPM by Category			
Procedure Category	Cost	Frequency	Class
Oral Evaluations	\$41.730	916.871	A
Prophylaxis	\$60.200	820.644	A
Fluoride	\$7.600	180.186	A
X-Rays	\$35.080	770.163	A
Lab & Other Tests	\$0.250	0.185	A
Emergency	\$0.940	16.588	A
Sealants	\$2.370	59.193	A
Space Maintainers	\$0.640	1.317	B
Simple Extraction	\$8.110	63.345	B
Amalgam Restorations	\$46.910	267.232	B
Composite Restorations*	\$33.140	193.772	B
Other Restorative Services	\$0.140	2.805	B
Non-Surgical Periodontics	\$12.080	49.764	B
Periodontic Maintenance	\$6.260	42.145	B
Other Periodontal Services	\$0.000	0.001	B
Endodontics - Primary Teeth	\$0.110	0.492	B
Endodontics - Root Canal	\$0.750	1.498	B
Endodontics	\$31.950	42.994	B
Repair (Simple) - Inlays & Crowns	\$0.516	8.463	B
Repair (Simple) - Prosthetics	\$0.314	3.568	B
Other Class 2 Prosthetics	\$0.726	3.002	B
Other Class 2 Prosthetics - Adjustments/Repairs	\$0.034	0.432	B
Anesthesia	\$3.710	18.547	C
Anesthesia - IV/Deep Sedation	\$1.000	11.352	C
Surgical Periodontics	\$6.680	6.164	C
Surgical Extraction	\$20.430	65.218	C
Oral Surgery	\$1.560	3.614	C
Inlays and Crowns	\$89.920	112.591	C
Dentures	\$6.850	7.385	C
Bridges	\$15.638	14.803	C
Bridges - Other Services	\$0.322	1.152	C
Other Class 3 Prosthetics	\$0.520	0.068	C
Consultation/Office Visit	\$0.76	0.007	C
Implants	\$1.770	51.060	C
* If Alternative Benefit Treatment does not apply, cost is \$34.39 pmpm			

Appendix A (Tables)

Table 1b: Waiting Period Factors	
Months	Factor
0	1.000
3	0.950
6	0.900
9	0.850
12	0.800
15	0.775
18	0.750
21	0.725
24	0.700

Table 2a: Deductible Credit	
Deductible	Credit Amount
\$0	\$0.000
\$25	\$1.000
\$50	\$2.000
\$75	\$2.950
\$100	\$3.850
\$125	\$4.700
\$150	\$5.500

Table 2b: Family Deductible Factor	
Deductible	Factor
\$0	1.000
\$25	0.894
\$50	0.899
\$75	0.905
\$100	0.911
\$125	0.916
\$150	0.921

Appendix A (Tables)

Table 2c: Deductible Class Allocation Factor		
Deductible	Class A Factor	Class B Factor
\$0	0.0%	0.0%
\$25	100.0%	100.0%
\$50	97.8%	100.0%
\$75	86.0%	100.0%
\$100	78.0%	99.8%
\$125	71.0%	99.4%
\$150	64.0%	98.9%

Table 3: Deductible Disincentive Factor	
Deductible	Factor
\$0	1.000
\$25	0.990
\$50	0.975
\$75	0.965
\$100	0.960
\$125	0.960
\$150	0.960

Table 5: Area Factors		
Zip Code	State	Factor
716	AR	0.922
717	AR	0.922
718	AR	0.922
719	AR	0.922
720	AR	0.922
721	AR	0.922
722	AR	0.922
723	AR	0.922
724	AR	0.922
725	AR	0.922
726	AR	0.922
727	AR	0.922
728	AR	0.922
729	AR	0.922

Appendix A (Tables)

Table 8: Anti-Selection Factors			
Coinsurance	Factor	Coinsurance	Factor
100/0/0	1.0000	50/0/0	1.3221
100/30/0	1.1497	50/30/0	1.4741
100/50/0	1.2154	50/50/0	1.5380
100/60/0	1.2148	50/60/0	1.5443
100/65/0	1.2201	50/65/0	1.5520
100/80/0	1.2464	50/80/0	1.5697
100/0/50	1.1046	50/0/50	1.4266
100/30/50	1.2625	50/30/50	1.5786
100/50/50	1.3332	50/50/50	1.6425
100/60/50	1.3451	50/60/50	1.6487
100/65/50	1.3600	50/65/50	1.6565
100/80/50	1.3850	50/80/50	1.6742
100/0/60	1.0420	50/0/60	1.3641
100/30/60	1.1940	50/30/60	1.5161
100/50/60	1.2579	50/50/60	1.5800
100/60/60	1.2641	50/60/60	1.5863
100/65/60	1.2719	50/65/60	1.5940
100/80/60	1.2896	50/80/60	1.6117
80/0/0	1.1997	0/0/0	1.8671
80/30/0	1.3517	0/30/0	2.0191
80/50/0	1.4156	0/50/0	2.0830
80/60/0	1.4218	0/60/0	2.0838
80/65/0	1.4296	0/65/0	2.0970
80/80/0	1.4473	0/80/0	2.1147
80/0/50	1.3042	0/0/50	1.9716
80/30/50	1.4562	0/30/50	2.1236
80/50/50	1.5201	0/50/50	2.1875
80/60/50	1.5263	0/60/50	2.1883
80/65/50	1.5341	0/65/50	2.2015
80/80/50	1.5518	0/80/50	2.2192
80/0/60	1.2417	0/0/60	1.9091
80/30/60	1.3937	0/30/60	2.0611
80/50/60	1.4576	0/50/60	2.1248
80/60/60	1.4638	0/60/60	2.1415
80/65/60	1.4716	0/65/60	2.1639
80/80/60	1.4893	0/80/60	2.2169

Appendix A (Tables)

Table 10: Annual Maximum Factor			
Annual Max	Factor	Annual Max	Factor
\$500	76.700%	\$1,850	102.495%
\$550	78.900%	\$1,900	102.704%
\$600	81.100%	\$1,950	102.914%
\$650	83.400%	\$2,000	103.123%
\$700	85.600%	\$2,050	103.333%
\$750	87.800%	\$2,100	103.544%
\$800	90.000%	\$2,150	103.754%
\$850	91.300%	\$2,200	103.965%
\$900	92.700%	\$2,250	104.176%
\$950	94.000%	\$2,300	104.387%
\$1,000	95.300%	\$2,350	104.598%
\$1,050	95.800%	\$2,400	104.809%
\$1,100	96.300%	\$2,450	105.021%
\$1,150	96.700%	\$2,500	105.233%
\$1,200	97.200%	\$2,550	105.445%
\$1,250	97.700%	\$2,600	105.445%
\$1,300	98.200%	\$2,650	105.658%
\$1,350	98.600%	\$2,700	105.658%
\$1,400	99.100%	\$2,750	105.870%
\$1,450	99.500%	\$2,800	105.870%
\$1,500	100.000%	\$2,850	106.083%
\$1,550	100.414%	\$2,900	106.083%
\$1,600	100.828%	\$2,950	106.296%
\$1,650	101.243%	\$3,000	106.296%
\$1,700	101.660%	\$5,000	107.151%
\$1,750	102.077%	\$10,000	107.365%
\$1,800	102.286%		

Appendix A (Tables)

Max From	Max To	Factor
\$1	\$500	1.000
\$501	\$1,000	1.000
\$1,001	\$1,500	1.000
\$1,501	\$2,000	1.000
\$2,001	\$2,500	0.990
\$2,501	\$3,000	0.975
\$3,001	\$3,500	0.940
\$3,501	\$4,000	0.875
\$4,001	\$4,500	0.785
\$4,501	\$5,000	0.695
\$5,001	\$5,500	0.630
\$5,501	\$6,000	0.595
\$6,001	\$6,500	0.560
\$6,501	\$7,000	0.525
\$7,001	\$7,500	0.490
\$7,501	\$8,000	0.455

Appendix B

Pediatric Contract Rate Calculation

Pediatric Contract Holders

Where applicable state law or regulation specifies pediatric contract holders, the following elements of the attached rating algorithm will differ accordingly.

Table 1a

In Step 1, the following table will be used (see next page):

Appendix B

Pediatric Contract Rate Calculation

Table 1a: Starting Claim Costs PMPM by Category - Pediatric Contract			
Procedure Category	Cost	Frequency	Class
Oral Evaluations	\$45.994	1,014.664	A
Prophylaxis	\$63.037	973.397	A
Fluoride	\$19.992	634.963	A
X-Rays	\$36.188	0.001	A
Lab & Other Tests	\$0.023	0.252	A
Emergency	\$0.658	7.821	A
Sealants	\$10.690	234.660	A
Space Maintainers	\$1.469	4.844	B
Simple Extraction	\$10.561	85.309	B
Amalgam Restorations	\$46.711	295.220	B
Composite Restorations	\$23.890	152.413	B
Other Restorative Services	\$0.001	0.001	B
Non-Surgical Periodontics	\$0.481	2.631	B
Periodontic Maintenance	\$0.128	1.000	B
Other Periodontal Services	\$0.001	0.001	B
Endodontics - Primary Teeth	\$0.278	1.176	B
Endodontics - Root Canal	\$8.451	10.089	B
Endodontics	\$1.689	11.013	B
Repair (Simple) - Inlays & Crowns	\$0.042	0.480	B
Repair (Simple) - Prosthetics	\$0.017	0.132	B
Other Class 2 Prosthetics	\$0.009	0.039	B
Other Class 2 Prosthetics - Adjustments/Repairs	\$0.001	0.002	B
Anesthesia	\$10.052	39.965	C
Anesthesia - IV/Deep Sedation	\$2.874	32.319	C
Surgical Periodontics	\$1.082	1.531	C
Surgical Extraction	\$33.815	94.075	C
Oral Surgery	\$2.201	6.796	C
Inlays and Crowns	\$9.271	19.280	C
Dentures	\$0.101	0.110	C
Bridges	\$0.750	0.970	C
Bridges - Other Services	\$0.004	0.017	C
Other Class 3 Prosthetics	\$0.001	0.002	C
Consultation/Office Visit	\$0.794	7.061	C
Implants	\$7.50	1.806	C
* If Alternative Benefit Treatment does not apply, cost is \$24.79 pmpm			

Appendix B

Pediatric Contract Rate Calculation

Tier Factors

In Step 14, tier factors will not be used. The PMPM Cost per child will generate a single rate. Where multiple children within a single family are covered under a single pediatric contract, the following volume discounts will be applied multiplicatively:

Multi-Child Discount Factor	
Number of Children	Factor
1	1.00
2	0.97
3	0.94
4	0.91
5 or more	0.88

Premium By Age Band

Uniage Premium is converted to Premium By Age Band using the following factors:

Age Under 6	0.45
Age 6 or More	1.00

All other elements of the attached rating algorithm remain in place.

SERFF Tracking Number: UCIN-128131350 State: Arkansas
 Filing Company: United Concordia Insurance Company State Tracking Number:
 Company Tracking Number: AR/UCIC/005-12
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: iDental 2012
 Project Name/Number: iDental Variability, Child-Only, HCR/AR/UCIC/005-12

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	04/02/2012
Comments:		
Attachment: Readability Certification.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	04/02/2012
Comments: New Application to be used is attached under the Form Schedule Tab.		

	Item Status:	Status Date:
Satisfied - Item: Health - Actuarial Justification	Approved-Closed	04/02/2012
Comments:		
Attachment: Indiv Memo AR 12.pdf		

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved-Closed	04/02/2012
Comments:		
Attachment: AR Outline of Coverage 0312 CLEAN.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variables	Approved-Closed	04/02/2012
Comments:		
Attachment:		

SERFF Tracking Number: UCIN-128131350 State: Arkansas
 Filing Company: United Concordia Insurance Company State Tracking Number:
 Company Tracking Number: AR/UCIC/005-12
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: iDental 2012
 Project Name/Number: iDental Variability, Child-Only, HCR/AR/UCIC/005-12
 Master Schedule of Benefits 0312 SOV.pdf

	Item Status:	Status Date:
Satisfied - Item: PDF Pipeline of Previously Approved Schedules 00 Series	Approved-Closed	04/02/2012
Comments: PDF Pipeline of previousl approved Schedules of Benefits INS-1-0309 - INS-5-0309		
Attachment: AR SERFF Filing 5199.pdf		

	Item Status:	Status Date:
Satisfied - Item: PDF Pipeline of Previouslly Approved Schedules 01 Series	Approved-Closed	04/02/2012
Comments: PDF Pipeline of previousl approved Schedules of Benefits INS-1-0311 - INS-5-0311		
Attachment: 2011 Approved SERFF UCIN-127062610.pdf		

	Item Status:	Status Date:
Satisfied - Item: Previously Approved Appeals Addendum	Approved-Closed	04/02/2012
Comments: Previously Approved Appeals Addendum to be used with this filing- approved under SERFF Tracking ID FRCS-126643128 on July 8, 2010.		
Attachment: Individual APPEAL PROCEDURE--Final 030409.pdf		

	Item Status:	Status Date:
Satisfied - Item: Previously Approved Exclusions and Limitations	Approved-Closed	04/02/2012
Comments:		

SERFF Tracking Number: UCIN-128131350 State: Arkansas
Filing Company: United Concordia Insurance Company State Tracking Number:
Company Tracking Number: AR/UCIC/005-12
TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
Product Name: iDental 2012
Project Name/Number: iDental Variability, Child-Only, HCR/AR/UCIC/005-12

Attachment:

Individual Es & Ls - Final.pdf

	Item Status:	Status Date:
Satisfied - Item: Red-Lined Documents	Approved-Closed	04/02/2012

Comments:

Marked up Policy & Outline of Coverage

Attachments:

AR Outline of Coverage 0312 MARKUP for submission.pdf

AR iDental Policy 0312 MARKUP for submission.pdf

	Item Status:	Status Date:
Satisfied - Item: Rate Calculation Example	Approved-Closed	04/02/2012

Comments:

Attachment:

Rate Calculation Example.pdf

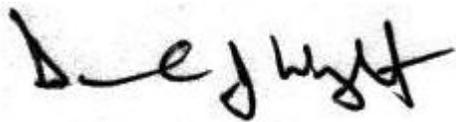
STATE OF ARKANSAS

READABILITY CERTIFICATION

UNITED CONCORDIA INSURANCE COMPANY

By signature below, it is certified that the forms listed below achieve a Flesch Reading Ease Score above the minimum reading ease score of 40 as required by the Arkansas Code Annotated § 23-80-206(a)(1).

Form Name	Form Number
Individual Application for Dental Insurance	ARINAPP-0312
Schedule of Benefits	INS-VAR-0312
Limiting Age Endorsement	INAgeVar 0312
Effect of Termination Endorsement	INVol/FraudLock 0312
Effect of Termination Endorsement	INFraudLock 0312
Effect of Termination Endorsement	INRemoveLock 0312



Daniel J. Wright
Treasurer, Vice-President and Controller

March 29, 2012
Date

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 the policyholder or an insured person applying for this coverage or filing a claim for benefits; 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 the policyholder lives. 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	<p>Several plan options are available. Your plan may cover:</p> <ul style="list-style-type: none"> • Exams; • X-rays; • Cleanings; • Fluoride treatments; • Palliative treatment (emergency); • Sealants; • Other diagnostic & preventive services; • Space maintainers; • Metal fillings; • White fillings; • Crowns, inlays, onlays; • Crown repair; • Endodontic therapy (root canals, etc.); • Other endodontic services; • Surgical periodontics; • Non-surgical periodontics; • Periodontal maintenance; • Complete or fixed partial dentures; • Denture adjustments and repairs; • Other prosthetic services; • Implant services; • Simple extractions; • Surgical extractions; • Oral surgery; • General anesthesia, nitrous oxide and/or IV sedation; • consultations; • adjunctive general services; and • Orthodontics. <p>Refer to the schedule of benefits in your policy to determine the services included in your plan and the amount the policy will pay.</p>

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; • orthodontics; 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.

United Concordia

STATEMENT OF VARIABILITY

This statement of variability applies to form INS-VAR-0312.

The above-referenced form is attached following this statement. Variable language is referenced in numbered sequence order. All variable language is supplied as referenced below.

1. This bracketed language allows the company to customize the plan number.
2. This bracketed language allows the plan to have no Deductible or a Deductible at one of the stated dollar amounts.
3. This bracketed language allows the plan to have an unlimited Contract Year Maximum or a Contract Year Maximum at one of the stated dollar amounts.
4. This bracketed language allows the plan to state that it does not cover Orthodontia or that the Orthodontia Lifetime Limit is one of the stated dollar amounts.
5. This bracketed language allows the plan to specify that there is no Waiting Period for the service (“none”), or, if the service is not covered, to specify that the Waiting Period is not applicable (“N/A”).
6. This bracketed language allows the plan to specify that there is no Waiting Period for the service (“none”), or to specify the Waiting Period in the number of months shown, or, if the service is not covered, to specify that the Waiting Period is not applicable (“N/A”).
7. This bracketed language allows the plan to specify, in the percentages shown, the payment amount for the service, or to state that the service is not covered.
8. This bracketed language allows the plan to specify that the Deductible applies to the service (“Yes”), does not apply to the service (“No”), or if there is no Deductible for the plan, that the Deductible is not applicable (“N/A”).

Schedule of Benefits

This Policy will pay benefits for Covered Services shown below subject to the Schedule of Exclusions and Limitations and other Policy terms. Payment is based on the Maximum Allowable Charge (MAC) for the specific Covered Service. Participating Dentists accept contracted MACs as payment in full for services. Non-participating Dentists do not limit their charges and may bill You for the difference between their charge and the benefit paid by the Policy.

Contract Year Deductible per Insured Person:	2 None; \$25; \$50; \$75; \$100}
Contract Year Maximum per Insured Person:	3 Unlimited; {\$500; \$750; \$1,000; \$1,200; \$1,250; \$1,500; \$1,750; \$2,000; \$2,500; \$3,000; \$3,500; \$4,000; \$4,500; \$5,000} }
Orthodontic Lifetime Maximum per Insured Person:	4 {Not Covered; \$500; \$1,000; \$1,500; \$2,000}

Service Category	Waiting Period	Policy Pays at		After Deductible
		Participating Dentists	Non-Participating Dentists	
Oral Evaluations (Exams)	5 {None; N/A}	7 {Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Radiographs (All X-Rays)	5 {None; N/A}	7 {Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Prophylaxis (Cleanings)	5 {None; N/A}	7 Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Fluoride Treatments	5 {None; N/A}	7 {Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Palliative Treatment (Emergency)	5 {None; N/A}	7 {Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Sealants	6 {None; {3; 6} months; N/A}	7 {Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Other Diagnostic & Preventive Services	6 {None; {3; 6} months; N/A}	7 {Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Space Maintainers	6 {None; {3; 6} months; N/A}	7 {Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Amalgam Restorations (Metal fillings)	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}

Resin-based Composite Restorations (White fillings)	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Crowns, Inlays, Onlays	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Crown Repair	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Endodontic Therapy (Root canals, etc.)	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Other Endodontic Services	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Surgical Periodontics	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Non-Surgical Periodontics	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Periodontal Maintenance	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}

Prosthetics (Complete or Fixed Partial Dentures)	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Adjustments and Repairs of Prosthetics	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Other Prosthetic Services	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Implant Services	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Simple Extractions	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Surgical Extractions	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Oral Surgery	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
General Anesthesia, Nitrous Oxide and/or IV Sedation	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}

Consultations	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Adjunctive General Services	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	7 {Not Covered; 20%; 25%; 30%; 35%; 40%; 45%; 50%; 55%; 60%; 65%; 70%; 75%; 80%; 85%; 90%; 95%; 100% }	8 {Yes; No; N/A}
Orthodontics (up to age 19)	6 {None; {3; 6; 9; 12; 15; 18; 21; 24} months; N/A}	7 Not Covered; 10%; 20%; 30%; 40%; 50%; 60%; 70%; 80%; 90%; 100% }	7 {Not Covered; 10%; 20%; 30%; 40%; 50%; 60%; 70%; 80%; 90%; 100% }	8 {Yes; No; N/A}

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

TOI: H10I Individual Health - Dental

Sub-TOI: H10I.000 Health - Dental

Filing Type: Form/Rate

SERFF Tr Num: FRCS-126643128 State: Arkansas

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

Co Tr Num: 5199

Co Status:

Authors: Jana Ellmaker, Kevin
Wiggs

Date Submitted: 05/28/2010

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 07/08/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

General Information

Project Name: UCCI/64

Project Number: 64

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 07/08/2010

Company Status Changed:

Deemer Date:

Submitted By: Jana Ellmaker

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.

This filing contains an individual dental policy, appeal procedure addendum, schedule of exclusions and limitations,

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

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

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

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

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

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*

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	%	%	\$		\$	%	%

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

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
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

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

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

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

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*

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

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

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**

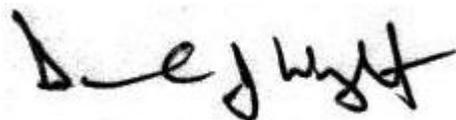
NOTICE OF RIGHT TO EXAMINE POLICY FOR 10 DAYS: The Policyholder may return this Policy within ten days of its delivery if, after examination of the Policy, the Policyholder is not satisfied with it for any reason. Upon return, the Company will refund all Premium paid. The Policy shall be void from the 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

Policyholder Name & Date of Birth: {John Doe} {XX/XX/XXXX}

Policy Number: As shown on your ID card

Effective Date: {XX/XX/XXXX}

Billing Frequency: {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 }

Dental Product Selected: 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

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

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

<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>		

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: Health - Actuarial Justification</p> <p>Comments:</p> <p>Attachments: AR Actuarial Memorandum.pdf Attachment A to Actuarial Memo.pdf</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>	Approved-Closed	07/08/2010

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

Attachment:

Auth_UCIC_4-10_dist.pdf

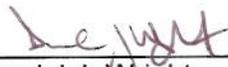
STATE OF ARKANSAS
READABILITY CERTIFICATION

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

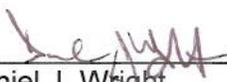
STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE

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 INSURANCE COMPANY
Actuarial Memorandum
- Page 1 -

Individual Dental Policy ARIN01-0310UCIC

Scope & Purpose:

The purpose of this filing is to submit rates for individual dental insurance in the State of Arkansas. This is UCIC's initial filing of individual products; previously all business in this state and countrywide has been group dental insurance.

Impact:

UCIC has not filed or sold any individual business at this time. This filing represents the initial offering of these rates.

Benefit Description:

Five benefit plans are currently being offered. Attachment A shows coinsurance and waiting periods for each benefit category as well as deductible and annual maximum benefit levels. All plans utilize a schedule of maximum allowable charges for covered services. UCIC's network of dentists accepts this schedule as payment in full. If the policy holder utilizes a non-network dentist or a non-covered benefit, that dentist may bill the member for amounts charged above the scheduled payment.

Renewability Clause:

The 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.

Applicability:

This form applies to all individual business.

Morbidity:

Individual business is expected to show utilization patterns which differ significantly from those currently experienced by UCIC's group business. Base rates were determined by evaluating:

- UCIC's small group rates in this state
- Rates offered by competitors in the individual dental market in this state
- National rating guidelines produced by external consultants
- National patterns of cost projections

Age factors are used to produce separate rates for policyholders below age 50 and those age 50 or more:

To Age 49	0.95
Age 50 +	1.20

Age factors are not applied to plan IND100. This particular benefit plan includes only Class I services as covered benefits, and since variation of utilization by age is expected to be minimal in Class I and pronounced in Class II and Class III, claims variance is expected to be level across ages for this plan only.

UNITED CONCORDIA INSURANCE COMPANY
Actuarial Memorandum
- Page 2 -

Individual Dental Policy ARIN01-0310UCIC

Modal factors are used to produce rates other than monthly billing:

Monthly	1.000
Quarterly	2.913
Semi-Annual	5.660
Annual	10.919

Expenses:

Administrative Expense	20%
Average Commission:	10%
Premium/other taxes:	Included in Administrative Expense
Profit, Risk and Contingency	5%

Marketing Method

All available methods of marketing this product may be used, including but not limited to brokers, company sales staff, direct mail and internet.

Underwriting:

The only Underwriting category which affects rates is the policy holder's age. Separate rates are shown for:

- Age Less Than 50
- Age 50 or Greater

Premium Classes:

Premiums are uni-sex and are 3-tiered. Available rating modes are monthly, quarterly, semi-annual and annual.

Trend Assumptions:

Base rates shown are for 12-month policies. Effective policy dates are shown with no trend embodied in the current filing. Estimated annual trend is expected to be 6.1%. No further trend will be applied without the filing of revised rates.

Minimum Loss Ratio

60.0%

Anticipated Loss Ratio

65.0%

The anticipated loss ratio represents (1 – "Expenses")

Contingency & Risk Margins:

5.0%

UNITED CONCORDIA INSURANCE COMPANY
Actuarial Memorandum

- Page 3 -

Individual Dental Policy ARIN01-0310UCIC

Experience – Arkansas and Countrywide

As this represents UCIC's initial filing of individual business, there is no historical experience, either state- or country-wide.

Credibility –

All projections have been based on consideration of multiple issues as discussed above. Future revisions to approved rates will address the credibility of existing business at that time.

Proposed Effective Date:

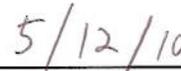
October 1, 2010

Actuarial Certification:

I, Rick S. Pawelski, am an actuary employed by United Concordia Companies, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries, and I meet the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion promulgated by the Actuarial Standards Board of the AAA insofar as they are applicable to this filing, which is recognized as a statement of actuarial opinion. I certify that the above statements are true and that, to the best of my knowledge and belief, this rate filing is in compliance with the applicable laws and regulations of this state and with all applicable Actuarial Standards of Practice. The benefits provided are reasonable in relation to the proposed premiums. The rates are neither inadequate nor excessive nor unfairly discriminatory, and are appropriate for the classes of risk for which they have been computed.



Rick S. Pawelski, FSA, MAAA



Date

**UCIC Individual Dental Insurance
Benefit Plans**

	IND100	IND200	IND300	IND400	IND500
Class I / Diagnostic and Preventive Services (No Waiting Period)					
• Exams	100%	100%	50%	100%	0%
• All X-Rays	100%	100%	50%	100%	0%
• Cleanings	100%	100%	50%	100%	0%
• Fluoride Treatments	100%	100%	50%	100%	0%
• Sealants	100%	100%	50%	100%	0%
• Palliative Treatment (Emergency)	100%	100%	50%	100%	0%
• Waiting Periods	None	None	None	None	None
Class II / Basic Services					
• Space Maintainers	0%	80%	50%	80%	0%
• Periodontal Maintenance	0%	80%	50%	80%	0%
• Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	0%	80%	50%	80%	0%
• Basic Restorative (Fillings, etc.)	0%	80%	50%	50%	60%
• Endodontics (Root canals, etc.)	0%	80%	50%	50%	60%
• Simple Extractions	0%	80%	50%	50%	60%
• Waiting Periods	None	None	None	None	None
Class III / Major Services					
• Complex Oral Surgery	0%	0%	0%	50%	60%
• General Anesthesia and/or Nitrous Oxide and/or IV Sedation	0%	0%	0%	50%	60%
• Non-surgical Periodontics	0%	0%	0%	50%	60%
• Surgical Periodontics	0%	0%	0%	50%	60%
• Crowns, Inlays, Onlays	0%	0%	0%	50%	60%
• Prosthetics (Fixed Partial Dentures, Dentures)	0%	0%	0%	50%	60%
• Implants	0%	0%	0%	50%	60%
• Waiting Periods	None	None	None	12 Months	6 Months
Deductible	\$ -	\$ 50	\$ 50	\$ 50	\$ 50
Annual Maximum	Unlimited	\$ 2,000	\$ 1,500	\$ 2,000	\$ 2,000

UNITED CONCORDIA

April 20, 2010

To: The Insurance Commissioner

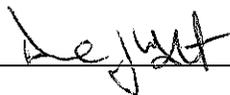
Authorization

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)

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

- 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.
- 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.
- 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:	UCIN-127062610	State:	Arkansas
Filing Company:	United Concordia Insurance Company	State Tracking Number:	48269
Company Tracking Number:	AR/UCIC/001-11		
TOI:	H10I Individual Health - Dental	Sub-TOI:	H10I.000 Health - Dental
Product Name:	Individual		
Project Name/Number:	iDental New Products/AR/UCIC/001-11		

Filing at a Glance

Company: United Concordia Insurance Company

Product Name: Individual

SERFF Tr Num: UCIN-127062610 State: Arkansas

TOI: H10I Individual Health - Dental

SERFF Status: Closed-Approved-Closed
State Tr Num: 48269

Sub-TOI: H10I.000 Health - Dental

Co Tr Num: AR/UCIC/001-11

State Status: Approved-Closed

Filing Type: Form/Rate

Co Status:

Reviewer(s): Rosalind Minor

Authors: Michelle Shutt, Benjamin Schaefer, Krista Maddigan, Kathleen McGonigle, Stacy Bell

Disposition Date: 03/18/2011

Date Submitted: 03/17/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

General Information

Project Name: iDental New Products

Status of Filing in Domicile: Pending

Project Number: AR/UCIC/001-11

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: AZ is the state of domicile and the filing is pending with AZ for approval.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 03/18/2011

Company Status Changed:

State Status Changed: 03/18/2011

Deemer Date:

Created By: Michelle Shutt

Submitted By: Benjamin Schaefer

Corresponding Filing Tracking Number:

Filing Description:

United Concordia Insurance Company (UCIC), a licensed accident and health insurer, is submitting this filing for approval. The filing contains five (5) new Schedules of Benefits and a revised application for the Individual Dental market.

The application replaces the prior Application for Dental Insurance, ARINAPP-0309, approved on 12/01/2010. The only change to the revised application is under the Plan Selection. The prior application had specific choices for the member to select and with the addition five (5) new schedules, we replaced the boxes with a fill-in blank line.

SERFF Tracking Number: UCIN-127062610 State: Arkansas
 Filing Company: United Concordia Insurance Company State Tracking Number: 48269
 Company Tracking Number: AR/UCIC/001-11
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: Individual
 Project Name/Number: iDental New Products/AR/UCIC/001-11

Company and Contact

Filing Contact Information

Ben Schaefer, Regulatory Compliance ucdoicorro@ucci.com
 Consultant
 4401 Deer Path Road 717-260-6911 [Phone]
 DPLR4 717-260-7494 [FAX]
 Harrisburg, PA 17110

Filing Company Information

United Concordia Insurance Company CoCode: 85766 State of Domicile: Arizona
 4401 Deer Path Road Group Code: 812 Company Type: LAH
 Harrisburg, PA 17110 Group Name: Highmark State ID Number:
 (800) 929-0538 ext. 57225[Phone] FEIN Number: 86-0307623

Filing Fees

Fee Required? Yes
 Fee Amount: \$300.00
 Retaliatory? No
 Fee Explanation: \$50 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Concordia Insurance Company	\$300.00	03/17/2011	45704336

SERFF Tracking Number: UCIN-127062610 State: Arkansas
Filing Company: United Concordia Insurance Company State Tracking Number: 48269
Company Tracking Number: AR/UCIC/001-11
TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
Product Name: Individual
Project Name/Number: iDental New Products/AR/UCIC/001-11

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/18/2011	03/18/2011

SERFF Tracking Number: UCIN-127062610 State: Arkansas
 Filing Company: United Concordia Insurance Company State Tracking Number: 48269
 Company Tracking Number: AR/UCIC/001-11
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: Individual
 Project Name/Number: iDental New Products/AR/UCIC/001-11

Disposition

Disposition Date: 03/18/2011

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	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: UCIN-127062610 State: Arkansas
 Filing Company: United Concordia Insurance Company State Tracking Number: 48269
 Company Tracking Number: AR/UCIC/001-11
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: Individual
 Project Name/Number: iDental New Products/AR/UCIC/001-11

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
Form	IND101 Schedule of Benefits	Approved-Closed	Yes
Form	IND201 Schedule of Benefits	Approved-Closed	Yes
Form	IND301 Schedule of Benefits	Approved-Closed	Yes
Form	IND401 Schedule of Benefits	Approved-Closed	Yes
Form	IND501 Schedule of Benefits	Approved-Closed	Yes
Form	Application for Individual Dental Insurance	Approved-Closed	Yes
Rate	AR Rates 01 Region 2 2011	Approved-Closed	Yes

SERFF Tracking Number: UCIN-127062610 State: Arkansas
 Filing Company: United Concordia Insurance Company State Tracking Number: 48269
 Company Tracking Number: AR/UCIC/001-11
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: Individual
 Project Name/Number: iDental New Products/AR/UCIC/001-11

Form Schedule

Lead Form Number: INS-1-0311

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/18/2011	INS-1-0311	Schedule Pages	IND101 Schedule of Benefits	Initial		0.000	Individual Dental Plan IND101 0311.pdf
Approved-Closed 03/18/2011	INS-2-0311	Schedule Pages	IND201 Schedule of Benefits	Initial		0.000	Individual Dental Plan IND201 0311.pdf
Approved-Closed 03/18/2011	INS-3-0311	Schedule Pages	IND301 Schedule of Benefits	Initial		0.000	Individual Dental Plan IND301 0311.pdf
Approved-Closed 03/18/2011	INS-4-0311	Schedule Pages	IND401 Schedule of Benefits	Initial		0.000	Individual Dental Plan IND401 0311.pdf
Approved-Closed 03/18/2011	INS-5-0311	Schedule Pages	IND501 Schedule of Benefits	Initial		0.000	Individual Dental Plan IND501 0311.pdf
Approved-Closed 03/18/2011	ARINAPP-0311	Application/ Enrollment Form	Application for Individual Dental Insurance	Revised	Replaced Form #: ARINAPP-0311 Previous Filing #: 45832	0.000	AR individual_enrollment--Revised 2011.pdf

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%
• Palliative Treatment (Emergency)	100%
Class II / Basic Services (No Waiting Period)	
• Sealants	0%
• Space Maintainers	0%
• Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	0%
• Basic Restorative (Fillings, etc.)	0%
• Simple Extractions	0%
Class III / Major Services (No Waiting Period)	
• Complex Oral Surgery	0%
• Endodontics (Root canals, etc.)	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%

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 all Covered Services)	\$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	100%
• All X-Rays	100%
• Cleanings	100%
• Fluoride Treatments	100%
• Palliative Treatment (Emergency)	100%
Class II / Basic Services (after a six (6) month Waiting Period)	
• Sealants	80%
• Space Maintainers	80%
• Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	80%
• Basic Restorative (Fillings, etc.)	80%
• Simple Extractions	80%
Class III / Major Services (No Waiting Period)	
• Complex Oral Surgery	0%
• Endodontics (Root canals, etc.)	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%

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 all Covered Services)	\$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%
• Palliative Treatment (Emergency)	50%
Class II / Basic Services (after a six (6) month Waiting Period)	
• Sealants	50%
• Space Maintainers	50%
• Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	50%
• Basic Restorative (Fillings, etc.)	50%
• Simple Extractions	50%
Class III / Major Services (No Waiting Period)	
• Complex Oral Surgery	0%
• Endodontics (Root canals, etc.)	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%

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 all Covered Services)	\$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	100%
• All X-Rays	100%
• Cleanings	100%
• Fluoride Treatments	100%
• Palliative Treatment (Emergency)	100%
Class II / Basic Services (after a six (6) month Waiting Period)	
• Sealants	80%
• Space Maintainers	80%
• Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	80%
• Basic Restorative (Fillings, etc.)	50%
• Simple Extractions	50%
Class III / Major Services (after a twelve (12) month Waiting Period)	
• Complex Oral Surgery	50%
• Endodontics (Root canals, etc.)	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%

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 Services)	\$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	0%
• All X-Rays	0%
• Cleanings	0%
• Fluoride Treatments	0%
• Palliative Treatment (Emergency)	60%
Class II / Basic Services (after a six (6) month Waiting Period)	
• Sealants	0%
• Space Maintainers	0%
• Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	0%
• Basic Restorative (Fillings, etc.)	60%
• Simple Extractions	60%
Class III / Major Services (after a six (6) month Waiting Period)	
• Complex Oral Surgery	60%
• Endodontics (Root canals, etc.)	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%

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.

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: <hr/>

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: 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.

LA & RI: 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.

KY: 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.

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

UNITED CONCORDIA
Insuring America's Dental Health

SERFF Tracking Number: UCIN-127062610 State: Arkansas
 Filing Company: United Concordia Insurance Company State Tracking Number: 48269
 Company Tracking Number: AR/UCIC/001-11
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: Individual
 Project Name/Number: iDental New Products/AR/UCIC/001-11

Rate Information

Rate data applies to filing.

Filing Method: 0
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: 0.000%
Effective Date of Last Rate Revision:
Filing Method of Last Filing: N/A

Company Rate Information

Company Name:	Company Rate Change:	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	N/A	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: UCIN-127062610 State: Arkansas
 Filing Company: United Concordia Insurance Company State Tracking Number: 48269
 Company Tracking Number: AR/UCIC/001-11
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: Individual
 Project Name/Number: iDental New Products/AR/UCIC/001-11

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 03/18/2011	AR Rates 01 Region 2 2011	ARIN01-0310UCIC, INS-1-0311, INS-2-0311, INS-3-0311, INS-4-0311, INS-5-0311	New		AR individua_enrollm ent--Revised MARK-UP.pdf

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	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 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 &** Any person who knowingly presents a false or fraudulent claim
- LA:** 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.
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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: UCIN-127062610 State: Arkansas
 Filing Company: United Concordia Insurance Company State Tracking Number: 48269
 Company Tracking Number: AR/UCIC/001-11
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: Individual
 Project Name/Number: iDental New Products/AR/UCIC/001-11

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	03/18/2011
Comments:		
Attachment: AR Readability (signed).pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	03/18/2011
Comments: A revised application is attached. A mark-up copy is provided for ease of review.		
Attachments: AR individual_enrollment--Revised 2011.pdf AR individua_enrollment--Revised MARK-UP.pdf		

	Item Status:	Status Date:
Satisfied - Item: Health - Actuarial Justification	Approved-Closed	03/18/2011
Comments: An actuarial memorandum and attachment "A" to the actuarial memorandum are attached here.		
Attachments: AR Actuarial Memorandum.pdf Att A UCIC.pdf		

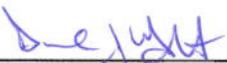
	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	03/18/2011
Bypass Reason: The Outline of Coverage (form number ARIN0C-0309UCIC) filed and approved under SERFF filing number FRCS-126643128/state tracking number 45832 will be used with the filed schedules of benefits.		
Comments:		

STATE OF ARKANSAS
READABILITY CERTIFICATION

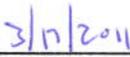
UNITED CONCORDIA INSURANCE COMPANY

By signature below, it is certified that the forms listed below achieve a Flesch Reading Ease Score above the minimum reading ease score of 40 as required by the Arkansas Code Annotated § 23-80-206(a)(1).

Form Name	Form Number
Individual Application for Dental Insurance	ARINAPP-0311
Schedule of Benefits	INS-1-0311
Schedule of Benefits	INS-2-0311
Schedule of Benefits	INS-3-0311
Schedule of Benefits	INS-4-0311
Schedule of Benefits	INS-5-0311



Daniel J. Wright
Treasurer, Vice-President and Controller



Date

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	Plan Selection: _____
	Premium Payment (\$): _____	

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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

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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

UNITED CONCORDIA
Insuring America's Dental Health

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	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 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

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- 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

UNITED CONCORDIA INSURANCE COMPANY
Actuarial Memorandum
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Individual Dental Policy ARIN01-0310UCIC

Scope & Purpose:

The purpose of this filing is to submit rates for new individual dental insurance plans in the State of Arkansas. UCIC currently offers 5 benefit plans with rates filed and approved by the Department: IND100, IND200, IND300, IND400 and IND500 (referred to hereafter as 00 plans). This filing proposes the addition of five different benefit plans: IND101, IND201, IND301, IND401, and IND501 (referred to hereafter as 01 plans). The benefit descriptions and proposed rates for these plans are attached to this filing.

The 00 plans have been in place since January 2010 in certain markets, however they were not sold in this state until November of 2010. Countrywide experience to this point has been unfavorable, with the ratio of actual to expected loss ratios exceeding 1.3 (see "Experience", below). This fact, combined with relatively high rates of lapsation for these policies, indicates a significant percentage of customers are purchasing coverage only to address preexisting conditions and dropping coverage shortly thereafter. The 01 benefit designs are based on those of the 00 plans, but several features have been changed to limit this risk:

- Endodontics have been moved to Class III
- Sealants have been moved to Class II
- All Periodontics have been moved to Class III
- \$2000 Annual Max has been changed to \$1500
- Deductible applies to all Classes in most cases
- A 6-month waiting period applies to Class II
- Implants are not covered

The pricing of the proposed 01 benefit plans is based on the approved levels for the 00 plans with adjustments for these benefit differences. The pricing does not reflect the emerging loss ratio experience of the 00 plans, since it is felt the adverse selection experienced to this point will be managed by the benefit plan changes for the 01 plans.

Impact:

The attached filing pertains only to revised benefit plans 101 - 501. As these plans have not been offered for sale yet, there will be no impact to any existing customers.

Benefit Description:

Attachment A shows benefit description for plans 101 - 501. All plans utilize a schedule of maximum allowable charges for covered services. UCIC's network of dentists accepts this schedule as payment in full. If the policy holder utilizes a non-network dentist or a non-covered benefit, that dentist may bill the member for amounts charged above the scheduled payment.

Renewability Clause:

The 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.

UNITED CONCORDIA INSURANCE COMPANY
Actuarial Memorandum
- Page 2 -

Individual Dental Policy ARIN01-0310UCIC

Applicability:

This form applies to all individual business. The attached rates apply solely to 01 benefit plans described above.

Morbidity:

This filing retains all morbidity assumptions from the currently approved filing of rates for this policy form, as follows:

Individual business is expected to show utilization patterns which differ significantly from those currently experienced by UCIC's group business. Base rates were determined by evaluating:

- UCIC's small group rates in this state
- Rates offered by competitors in the individual dental market in this state
- National rating guidelines produced by external consultants
- National patterns of cost projections

Age factors are used to produce separate rates for policyholders below age 50 and those age 50 or more:

To Age 49	0.95
Age 50 +	1.20

Age factors are not applied to plan IND101. This particular benefit plan includes only Class I services as covered benefits, and since variation of utilization by age is expected to be minimal in Class I and pronounced in Class II and Class III, claims variance is expected to be level across ages for this plan only.

Modal factors are used to produce rates other than monthly billing:

Monthly	1.000
Quarterly	2.913
Semi-Annual	5.660
Annual	10.919

Area factors are discussed below.

Expenses:

Administrative Expense	20%
Average Commission:	10%
Premium/other taxes:	Included in Administrative Expense
Profit, Risk and Contingency	5%

Marketing Method

All available methods of marketing this product may be used, including but not limited to brokers, company sales staff, direct mail and internet.

UNITED CONCORDIA INSURANCE COMPANY
Actuarial Memorandum
- Page 3 -

Individual Dental Policy ARIN01-0310UCIC

Underwriting:

The only Underwriting category which affects rates is the policy holder's age. Separate rates are shown for:

- Age less than 50
- Age 50 or greater

Premium Classes:

Premiums are uni-sex and are 3-tiered. Available rating modes are monthly, quarterly, semi-annual and annual.

Trend Assumptions:

Submitted rates are for the 12-month period beginning 6/1/2011. It is expected that annual trend and rate adequacy will be evaluated annually, with separate submission of any required filings. No further trend will be applied beyond 5/31/2012 without the filing of revised rates.

Minimum Loss Ratio

60.0%

Anticipated Loss Ratio

65.0%

The anticipated loss ratio represents (1 – "Expenses")

Contingency & Risk Margins:

5.0%

Experience

Since existing individual dental products have only been offered in this state since November of 2011, no usable experience data has accrued at the state level. Historical experience for existing individual dental insurance for countrywide business under the currently approved benefit plans (00 plans) is provided in the following table (experience was incurred from 1/1/2010 to 12/31/2010):

	Contract	Written	Earned	Paid	Incurred	Loss
	<u>Months</u>	<u>Premium</u>	<u>Premium</u>	<u>Claims</u>	<u>Claims</u>	<u>Ratio</u>
Countrywide	30,997	1,835,592	1,650,712	1,579,101	1,632,791	98.90%

Credibility –

Since limited experience is available, no credibility has been assigned to existing business. All projections are based on consideration of multiple issues as discussed above. Future revisions to approved rates will address the credibility of existing business at that time.

Proposed Effective Date:

June 1, 2011

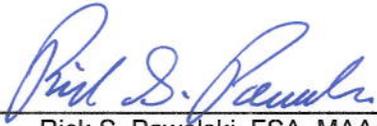
UNITED CONCORDIA INSURANCE COMPANY
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Individual Dental Policy ARIN01-0310UCIC

Actuarial Certification:

I, Rick Pawelski, am an actuary employed by United Concordia Companies, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries, and I meet the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion promulgated by the Actuarial Standards Board of the AAA insofar as they are applicable to this filing, which is recognized as a statement of actuarial opinion. I certify that the above statements are true and that, to the best of my knowledge and belief, this rate filing is in compliance with the applicable laws and regulations of this state and with all applicable Actuarial Standards of Practice. The benefits provided are reasonable in relation to the proposed premiums. The rates are neither inadequate nor excessive nor unfairly discriminatory, and are appropriate for the classes of risk for which they have been computed.



Rick S. Pawelski, FSA, MAAA

3/15/11

Date

Attachment A

**United Concordia Insurance Co.
Individual Dental Insurance
Benefit Plans**

	IND101	IND201	IND301	IND401	IND501
Class I / Diagnostic and Preventive Services (No Waiting Period)					
· Exams	100%	100%	50%	100%	0%
· All X-Rays	100%	100%	50%	100%	0%
· Cleanings	100%	100%	50%	100%	0%
· Fluoride Treatments	100%	100%	50%	100%	0%
· Palliative Treatment (Emergency)	100%	100%	50%	100%	60%
· Waiting Periods	None	None	None	None	None
Class II / Basic Services					
· Sealants	0%	80%	50%	80%	0%
· Space Maintainers	0%	80%	50%	80%	0%
· Repairs of Crowns, Inlays, Onlays, Fixed Partial Dentures, and Dentures	0%	80%	50%	80%	0%
· Basic Restorative (Fillings, etc.)	0%	80%	50%	50%	60%
· Simple Extractions	0%	80%	50%	50%	60%
· Waiting Periods	None	6 Months	6 Months	6 Months	6 Months
Class III / Major Services					
· Complex Oral Surgery	0%	0%	0%	50%	60%
· Endodontics (Root Canals, etc.)	0%	0%	0%	50%	60%
· General Anesthesia and/or Nitrous Oxide and/or IV Sedation	0%	0%	0%	50%	60%
· Non-surgical Periodontics	0%	0%	0%	50%	60%
· Surgical Periodontics	0%	0%	0%	50%	60%
· Crowns, Inlays, Onlays	0%	0%	0%	50%	60%
· Prosthetics (Fixed Partial Dentures, Dentures)	0%	0%	0%	50%	60%
· Waiting Periods	None	None	None	12 Months	6 Months
Deductible	\$ 0	\$50 (All Classes)	\$50 (All Classes)	\$50 (All Classes)	\$50 (Classes II and III)
Annual Maximum	Unlimited	\$ 1,500	\$ 1,500	\$ 1,500	\$ 1,500

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 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.

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 person 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 the policyholder lives. 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	<p>Several plan options are available. Your plan may cover:</p> <ul style="list-style-type: none"> • <u>Exams;</u> • <u>X-rays;</u> • <u>Cleanings;</u> • <u>Fluoride treatments;</u> • <u>Palliative treatment (emergency);</u> • <u>Sealants;</u> • <u>Other diagnostic & preventive services;</u> • <u>Space maintainers;</u> • <u>Metal fillings;</u> • <u>White fillings;</u> • <u>Crowns, inlays, onlays;</u> • <u>Crown repair;</u> • <u>Endodontic therapy (root canals, etc.);</u> • <u>Other endodontic services;</u> • <u>Surgical periodontics;</u> • <u>Non-surgical periodontics;</u> • <u>Periodontal maintenance;</u> • <u>Complete or fixed partial dentures;</u> • <u>Denture adjustments and repairs;</u> • <u>Other prosthetic services;</u> • <u>Implant services;</u> • <u>Simple extractions;</u> • <u>Surgical extractions;</u> • <u>Oral surgery;</u> • <u>General anesthesia, nitrous oxide and/or IV sedation;</u> • <u>consultations;</u> • <u>adjunctive general services; and</u> • <u>Orthodontics.</u> <p> • 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 </p> <p>Refer to the schedule of benefits in your policy to determine the services included in your plan and the <u>percentage amount</u> the policy will pay.</p>
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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; • <u>orthodontics</u>; and • <u>-dental implants</u>. • <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	<p>There are no pre-existing condition limitations under this policy.</p>

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

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~~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 those Insured Persons enrolled by 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.

F. L. C. King (Marked)

Company Officer

D. E. King

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
- [State Law Provisions Addendum](#)
- [Endorsement\(s\), if applicable](#)

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.

Contract Year – The period of twelve (12) months beginning on the Effective Date or the anniversary of the Effective Date and ending on the day before the Renewal Date.

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(s) – 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.

Family Policy – A Policy that covers the Policyholder and may also cover eligible Dependents, as defined in the Eligibility and Effective Date section. A Policy that covers only a child or only children is not a Family 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(s) - The greatest amount the Policy will allow for a specific service.

Insured Person(s) - ~~Policyholder and~~ Individuals enrolled ~~dependents~~ under the Policyholder’s plan. Also referred to as “You,” “Your” or “Yourself.”

Non-Participating Dentist(s) - A Dentist who has not contracted with ~~the Company or its affiliate~~ Us to limit his/her charges to Insured Persons.

Out-of-Pocket Expense(s) – Costs not paid by Us, including but not limited to Coinsurance, Deductibles, amounts billed by Non-Participating Dentists that are over the Maximum Allowable Charge, costs of services that exceed the Policies Limitations or Maximums, or for services that are Exclusions. The Insured Person is responsible to pay for Out-of-Pocket Expenses.

Participating Dentist(s) - A Dentist who has executed a Participating Dentist ~~Agreement~~ agreement with ~~the Company or an affiliate of the Company~~ Us, under which he/she agrees to accept ~~the Company’s~~ Maximum Allowable Charges as payment in full for Covered Services. Participating Dentists may also agree to limit their charges for any other services delivered to Insured Persons.

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~~Schedule who has purchased this dental insurance ~~for him/herself and any Dependents. Also referred to as “You”. In the case of a policy covering only a child or “Your” only children, the Policyholder is the child/children’s parent, legal guardian or “Yourself” legal custodian.~~

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

Renewal Date - The date the Policy renews.

Schedule of Benefits - Attached summary of Covered Services, Policy ~~payment percentages~~payments, 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.

Spouse – The Policyholder’s partner by marriage or by any union between two adults that is recognized by law in the state where this Policy is issued.

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.

We, Our or Us - The Company, its affiliate or an organization with which it contracts for a provider network and/or to perform certain functions to administer this Policy.

ELIGIBILITY AND EFFECTIVE DATE

In order to become insured, You must ~~supply~~meet the eligibility requirements of this Policy and any additional eligibility requirements that may be imposed by law or regulation. We must receive information ~~on Yourself and Your Dependents, select~~ about the Policyholder, Insured Persons, the selected dental product, payment method, and billing frequency. ~~Your coverage and Your Dependents’ coverage~~ Coverage will begin on the first day of the month following receipt of enrollment ~~or on any such date as may be specified in the enrollment information We receive from an authorized private or government entity.~~ 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:

~~Your spouse~~When a Policy covering only a child or only children is purchased, the Policyholder’s natural children, adoptive children or children under the legal custody of or placed with the Policyholder by a court or administrative agency are eligible as Insured Persons up to the “Limiting Age” of eighteen (18). Dependents, defined below, are not eligible for coverage under a child-only Policy. Each child can be covered under only one (1) Policy issued by Us, either a child-only Policy or a Family Policy, at the Policyholder’s option. If a child is enrolled in more than one (1) Policy issued by Us, the Policyholder must select the Policy from which to terminate the child’s coverage and any unearned Premium for that Policy will be returned to the Policyholder.

“Dependents” eligible for coverage in a Family Policy include:

1. The Policyholder’s 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 twenty-six (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~~the Effective Date, ~~You of a Family Policy, the Policyholder~~ may add Dependents if they meet the requirements detailed above and ~~You supply~~ the required change information is provided to Us. The Policyholder may also add or remove Dependents or change benefit plans during the timeframes specified by applicable law or regulation. 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 on the date dictated by applicable law or regulation. Future bills~~ 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 in a Family Policy 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 in a Family Policy 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. In Policies that cover only a child or only children, newborns of Insured Persons are not eligible for coverage.

Dependent

For Family Policies, coverage will end at 12:00 midnight the last day of the month during which one of the following occurs, or on the date dictated by applicable law or regulation:

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

For a Policy that covers only a child or only children, coverage will end on the last day of the Contract Year during which the child reaches the Limiting Age specified above unless terminated earlier as specified under the Policy Termination section or unless a different termination date is specified by an authorized private or governmental entity or by applicable law or regulation. For children reaching the Limiting Age, We will notify You in advance that You have a conversion period after Your Termination Date to convert to a Family Policy. If You convert to a Family Policy during the conversion period, any applicable Waiting Periods in the Family Policy will be credited for the time that You were insured under the prior Policy, and You will not have a lapse in coverage. After the conversion period expires, You must re-enroll in a Family Policy and the full Waiting Period will apply before You are eligible for benefits.

Notification of divorce, legal dissolution of the union with a Spouse 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~~the next bill.

For an enrolled Dependent child who is mentally or physically handicapped, evidence of his/her reliance on ~~You~~the Policyholder or the Policyholder’s Spouse for maintenance and support due to ~~his/her~~the child’s condition must be supplied within sixty (60) days of Our request. Such evidence ~~will be based on~~must include information provided by the Insured Person’s physician and will be requested no more frequently than annually.

CONVERSION FOR DEPENDENTS

~~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.~~

~~When a Spouse or child loses eligibility or is terminated for another reason from a Family Policy, the former Spouse or child must re-apply for coverage. Waiting Periods will apply before You are eligible for benefits under the new Policy.~~

If this Policy covers only ~~an individual Policyholder~~ one Insured Person 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 ~~that a Family Policy covers Dependents or~~ the Policy covers ~~Dependents only a child/children~~ at the time of the Policyholder's death, ~~his/her~~ the Policyholder's enrolled surviving spouse ~~Spouse or, if no Spouse is enrolled, an enrolled child of legal contracting age~~ will become the Policyholder, and Premium will be adjusted accordingly. A surviving ~~spouse~~ 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~~ rates in effect on ~~Your~~ the Policy's 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~~ "Grace Period" of ~~thirty-one (31)~~ thirty-one (31) days will be granted for payment of the overdue Premium. ~~unless a longer Grace Period is required by law or regulation.~~ If payment is not remitted by the end of the ~~grace period~~ 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~~ Grace Period will not apply if, at least ~~thirty (30)~~ thirty (30) days before the due date, We have delivered or mailed to ~~you~~ the Policyholder's last known address written notice of ~~our~~ Our intent not to renew this Policy.

Reinstatement: If any ~~renewal~~ Premium is not paid within the ~~grace period for payment~~ Grace Period specified above, 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 ~~forty-fifth (45th)~~ forty-fifth (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 ~~sixty (60)~~ sixty (60) days prior to the date of reinstatement.

Misstatement of Age: If the age of ~~the any~~ 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.

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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 sixty (60) days advance notice of any change in Premium at renewal.
2. ~~You as the~~The Policyholder may elect ~~not to renew~~terminate the Policy on ~~Your~~the Renewal Date. ~~If You elect not to renew, You will not be or on any other date permitted to apply for new dental insurance for Yourself or Your Dependents for three (3) years from the Termination Date by applicable law or regulation.~~
3. ~~You as the~~The Policyholder may change dental products at renewal ~~by notifying Us and during the timeframes specified by applicable law or regulation.~~ Replacement Schedules of Benefits and Exclusions and Limitations depicting the product choice will be supplied ~~to You.~~ Any applicable ~~benefit~~ Waiting Periods in the new plan selected will be applied as if You are a new Policyholder credited for the amount of time that You have been enrolled in the Policy. Any change in Premium will be included on ~~Your~~the next bill.
4. We may elect not to renew the Policy with sixty (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/Insured Person applying for this coverage or filing a claim for benefits;
 - b) ~~You as the~~The Policyholder or an insured Dependent/Insured Person 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

Policy Termination Reasons: 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~~The Policyholder may voluntarily 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~~the written notice unless a different termination date is required by law or regulation, or 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. Premium was paid.
3. We may decline to renew the Policy as provided by Provision 4 of the above renewal clause; ~~or.~~
4. ~~The Policyholder dies, if this~~This Policy ~~covered~~will terminate if it covers only one (1) Insured Person and he/she dies.
5. This Policy will terminate if it covers only one (1) Insured Person and an authorized private or government entity notifies Us that individual he/she is no longer eligible for coverage.

Effect of Termination: For a Family Policy, the Policyholder will not be permitted to re-enroll himself/herself for three (3) years (the "Lock-out Period") from the Termination Date if the Policyholder voluntarily terminates the Policy at renewal or on any other date, or if the Policy is terminated for fraud, material misrepresentation, or non-payment of Premium. Lock-out Periods do not apply to Policies covering only a child or only children.

If the Policyholder voluntarily terminates a Family Policy in order to apply for a Policy covering only a child or only children, the Policyholder must submit a new application for the child/children's coverage. Benefits under the new child-only or children-only Policy will be paid after any applicable Waiting Periods and/or Deductibles are met.

The Lock-out Period does not apply if the Policyholder voluntarily terminates a Policy covering only a child or only children and submits a new application for a Family Policy. Benefits under the new Family Policy will be paid after any applicable Waiting Periods and/or Deductibles are met.

Benefits After Coverage Terminates: We are not liable to pay any benefits for services which are started after the ~~Termination Date of~~ Insured Person's ~~coverage or of the Policy.~~Termination Date. However, coverage for completion of a dental procedure requiring two (2) or more visits on separate days will be extended for a period of ninety (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~~**Insured Persons** may choose any licensed Dentist for services. However, ~~if You choose~~**choosing** a Participating Dentist, ~~You~~ may limit ~~Your out~~**Out-of-pocket cost**~~Pocket Expenses~~. Participating Dentists limit their fees to their contracted Maximum Allowable Charges for Covered Services. Also, if agreed by the provider, Participating Dentists limit their charges for all services delivered to Insured Persons, even if the service is not covered for any reason and a benefit is not paid under this Policy. 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~~**When using a Non-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~~**Out-of-pocket costs**~~Pocket Expenses~~.

Schedule of Covered Services

~~Your benefits~~ **Benefits** and any applicable **Deductibles, Maximums and Waiting Periods** 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~~**When treatments are performed by a Participating Dentist**, We will ~~send payment for Covered Services~~**pay covered benefits** 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.~~**Our payment and any Out-of-Pocket Expenses**. 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~~**Us** 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~~**When treatments are performed by** a Non-Participating Dentist, We will send payment for Covered Services to You unless ~~You indicate on~~ the claim **indicates** that ~~You wish~~ payment **should** be sent directly to ~~Your~~**the** treating Dentist. This is called assignment of benefits, and it is available for care delivered by Non-Participating Dentists outside of Pennsylvania ~~or~~**and** West Virginia. You will still be notified of the services covered, ~~our~~**Our** payment and any ~~amounts owed for Coinsurance, Deductibles, charges exceeding annual Maximums or charges for services not covered.~~**Out-of-Pocket Expenses**. 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~~**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.

Value-Added Programs and Services

From time to time, We offer Insured Persons access to various lifestyle, health and/or value-added programs and services. Such offerings are subject to change at any time without notice. Contact your agent or call Customer Service for eligibility requirements and other information. Eligibility requirements for these programs and services are applied in a uniform, non-discriminatory manner to all Insured Persons.

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~~ Upon receipt of a notice of claim, ~~We~~ We will furnish to the Insured Person such forms as are usually furnished by ~~it~~Us for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after ~~the Company~~We 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~~Us at ~~its~~Our said office within ~~ninety (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~~Our 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~~[The Company's](#) 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~~[The Company](#) 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~~[the Policyholder lives](#) 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 ~~sixty~~ [sixty \(60\)](#) 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

Policyholder Name & Date of Birth:	{John Doe}	{XX/XX/XXXX}
Policy Number:	As shown on your ID card	
Effective Date:	{XX/XX/XXXX}	
Billing Frequency:	{Monthly, Quarterly, Semi-Annually, Annually}	
Type of Coverage & Premium Rates:	{Policyholder only Only}	{\$ 12.34 XX.XX}
	{Policyholder and One Dependent}	{\$ 45.67 XX.XX}
	{Family}	{\$ 100.00 XXX.XX}
	<u>{Child Only}</u>	<u>{\$XX.XX}</u>
	<u>{Children Only}</u>	<u>{\$XX.XX}</u>
Dental Product Selected:	Plan {XXXXXX, XXXXXX , XXXXXX , XXXXXX , XXXXXX }	
<u>{Enrollment Fee:}</u>	<u>{\$XX}</u>	
<u>{Service Fee (applied on each Premium invoice):}</u>	<u>{\$XX}</u>	