UNITED CONCORDIA® DENTAL

Dental Programs for Maryland Employer Groups with 10-50 Enrolled Contracts

Valid programs and rates for effective dates of July 1, 2020 through December 31, 2020.
Rates are guaranteed for 24 months from the effective date, provided the group meets underwriting guidelines.
The rates on this card do not apply to existing United Concordia Dental groups.

FFS PRODUCTS	Flex	Flex	Flex	Preferred		Preferred	
UNITED CONCORDIA DENTAL PLAN OPTION							
Standard Plan Option	**F-2W**	**F-3W**	**F-3Wo***	**P-10W**		**P-4W**	
CLASS I SERVICES				Network	Non-Network	Network	Non-Network
Exams, Cleanings & Fluoride Treatments							
All X-Rays							
Sealants	100%	100%	100%	100%	80%	100%	100%
Palliative Treatment (Emergency)							
Space Maintainers							
CLASS II SERVICES				Network	Non-Network	Network	Non-Network
Basic Restorative (Fillings, etc.)							
Posterior Resins (White Fillings)							
Repairs (Crowns, Inlays, Onlays, Bridges, Dentures)							
Oral Surgery (including Extractions)	80%	80%	80%	80%	60%	90%	80%
General Anesthesia							
Endodontics							
Periodontics (Surgical and Nonsurgical)							
Posterior Resins (White Fillings)							
CLASS III SERVICES				Network	Non-Network	Network	Non-Network
Inlays, Onlays, Crowns	Not Covered	50%	50%	50%	50%	60%	50%
Prosthetics (Bridges, Dentures)							
ORTHODONTICS (dependent children to age 19)				Network	Non-Network	Network	Non-Network
Diagnostic, Active, Retention Treatment	Not Covered	Not Covered	50%	Not Covered	Not Covered	Not Covered	Not Covered
Waiting Periods							
Class I services	None	None	None	None		None	
Class II services	None	None	None	None		None	
Class III services	Not Covered	None	None	None		None	
Orthodontic services	Not Covered	Not Covered	None	Not Covered		Not Covered	
DEDUCTIBLES & MAXIMUMS							
Calendar Year Deductible (Flex: waived for Class I services) (Preferred: waived for Orthodontic & In-Network Class I services)	$50/$150	$50/$150	$50/$150	$50/$150		$50/$150	
Orthodontics (Lifetime Maximum)	Not Covered	Not Covered	$1,000	Not Covered		Not Covered	
Network							
Network Reimbursement	Elite Plus	Elite Plus	Elite Plus	Elite Plus		Elite Plus	
Out-of Network Reimbursement	MAC	MAC	MAC		MAC		MAC
Plan Features							
Smile for Health - Wellness Provides periodontal care for people with certain chronic medical conditions. Eligible conditions: diabetes, heart disease, stroke, rheumatoid arthritis, lupus, organ transplant and head & neck radiation.	♦Covers 1 additional periodontal maintenance per year and all are covered at 100% ♦Scaling and root planing are covered at 100% ♦4 periodontal surgery procedures are covered at 100%						

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FFSTemp07012012

United Concordia Dental PPO Plans

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MD Metro

Valid in the following zip codes: 208xx - 209xx

Minimum Enrollment & Participation	Groups 10-50				
Minimum Enrolled	10	10	10[a]	10	10
Minimum Participation	**70%**	**70%**	**70%**	**70%**	**70%**

STANDARD PLAN OPTION		F-2W	F-3W	F-3Wo[a]	P-10W	P-4W
$1,000 Calendar Year Maximum						
Two-Tier	Employee	$21.40	$31.20	$31.20	$29.70	$30.60
	Family	$63.10	$92.10	$104.40	$87.90	$90.70
Four-Tier	Employee	$21.40	$31.20	$31.20	$29.70	$30.60
	Employee & 1 Adult	$49.40	$72.20	$72.20	$69.00	$71.20
	Employee & Child(ren)	$44.70	$65.20	$77.30	$62.30	$64.20
	Family	$74.60	$109.10	$121.20	$104.20	$107.40
$1,500 Calendar Year Maximum						
Two-Tier	Employee	$22.40	$32.70	$32.70	$31.10	$32.10
	Family	$66.10	$96.50	$108.80	$92.30	$95.20
Four-Tier	Employee	$22.40	$32.70	$32.70	$31.10	$32.10
	Employee & 1 Adult	$51.80	$75.80	$75.80	$72.50	$74.70
	Employee & Child(ren)	$46.80	$68.40	$80.50	$65.40	$67.40
	Family	$78.20	$114.40	$126.50	$109.40	$112.80
$3,000 Calendar Year Maximum						
Two-Tier	Employee	$23.80	$34.70	$34.70	$33.10	$34.10
	Family	$70.10	$102.50	$114.80	$98.20	$101.20
Four-Tier	Employee	$23.80	$34.70	$34.70	$33.10	$34.10
	Employee & 1 Adult	$55.00	$80.40	$80.40	$77.10	$79.40
	Employee & Child(ren)	$49.70	$72.60	$84.70	$69.50	$71.70
	Family	$83.00	$121.40	$133.50	$116.30	$119.90

MD Non-Metro

Valid in the following zip codes: 206xx - 207xx, 210xx - 219xx

Minimum Enrollment & Participation		Groups 10-50				
Minimum Enrolled		10	10	10[a]	10	10
Minimum Participation		**70%**	**70%**	**70%**	**70%**	**70%**
STANDARD PLAN OPTION		**F-2W**	**F-3W**	**F-3Wo***	**P-10W**	**P-4W**
$1,000 Calendar Year Maximum						
Two-Tier	Employee	$18.70	$27.20	$27.20	$25.70	$26.50
	Family	$55.00	$80.20	$92.50	$76.30	$78.70
Four-Tier	Employee	$18.70	$27.20	$27.20	$25.70	$26.50
	Employee & 1 Adult	$43.00	$62.90	$62.90	$59.80	$61.70
	Employee & Child(ren)	$39.00	$56.80	$68.90	$54.10	$55.70
	Family	$65.00	$94.90	$107.10	$90.30	$93.10
$1,500 Calendar Year Maximum						
Two-Tier	Employee	$19.60	$28.50	$28.50	$27.00	$27.90
	Family	$57.60	$84.10	$96.40	$80.10	$82.60
Four-Tier	Employee	$19.60	$28.50	$28.50	$27.00	$27.90
	Employee & 1 Adult	$45.10	$66.00	$66.00	$62.80	$64.80
	Employee & Child(ren)	$40.90	$59.60	$71.70	$56.80	$58.50
	Family	$68.10	$99.60	$111.70	$94.90	$97.80
$3,000 Calendar Year Maximum						
Two-Tier	Employee	$20.80	$30.20	$30.20	$28.70	$29.60
	Family	$61.10	$89.30	$101.50	$85.20	$87.80
Four-Tier	Employee	$20.80	$30.20	$30.20	$28.70	$29.60
	Employee & 1 Adult	$47.90	$70.00	$70.00	$66.80	$68.90
	Employee & Child(ren)	$43.30	$63.20	$75.30	$60.30	$62.20
	Family	$72.30	$105.70	$117.80	$100.90	$104.00

* In order for a group with 10-24 enrolled contracts to qualify for dependent orthodontic coverage, the group must provide proof of prior fee-for-service orthodontic coverage.
For use with rate card FFSTemp072012

Underwriting Guidelines

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

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

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

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

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

THIS PLAN DOES NOT MEET THE MINIMUM ESSENTIAL HEALTH BENEFIT REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE FEDERAL AFFORDABLE CARE ACT.

THIS SCHEDULE APPLIES ONLY TO COVERAGE FOR INDIVIDUALS AGES 19 AND OLDER.

Only American Dental Association procedure codes are covered.

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

1. Started within the twelve (12) months prior to the Member's Effective Date, if services are incurred before the Member has been covered for twelve (12) months under the Group Policy, or after the Termination Date of coverage under the Group Policy (for example but not limitation multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).
3. For prescription and non-prescription drugs, vitamins or dietary supplements.
4. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.
5. Which are Cosmetic in nature as determined by the Company (for example but not limitation, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).
6. Elective procedures (for example but not limitation, the prophylactic extraction of third molars).
7. For congenital mouth malformations or skeletal imbalances (for example but not limitation, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).
8. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the Schedule of Benefits or a Rider.
9. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
10. For treatment of fractures and dislocations of the jaw.
11. For treatment of malignancies or neoplasms.
12. Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
13. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
14. Preventive restorations.
15. Periodontal splinting of teeth by any method.
16. For duplicate dentures, prosthetic devices or any other duplicative device.
17. For which in the absence of insurance the Member would incur no charge. This exclusion does not apply to Medicaid or reimbursement to the MD Department of

Health and Mental Hygiene.

18. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
19. 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.
20. For treatment and appliances for bruxism (night grinding of teeth).
21. Incomplete treatment (for example but not limitation, patient does not return to complete treatment) unless the treatment is not completed at the advice of a Dentist due to a medical or dental condition that in the Dentist's opinion makes completion of the treatment inadvisable and temporary services (for example but not limitation, temporary restorations).
22. Procedures that are:
    - part of a service but are reported as separate services; or
    - reported in a treatment sequence that is not appropriate; or
    - misreported or that represent a procedure other than the one reported.
23. Specialized procedures and techniques (for example but not limitation, precision attachments, copings and intentional root canal treatment).
24. Fees for broken appointments.
25. Those specifically listed in the Schedule of Benefits as "Not Covered" or "Plan Pays 0%".
26. 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.
27. For prosthetic services (for example but not limitation, full or partial dentures or fixed bridges) if such services replace one (1) or more teeth missing during the twelve (12) months prior to Member's eligibility under the Group Policy, if services are incurred before the Member has been covered for twelve (12) months under the Group Policy.
28. Fluoride treatment; Space maintainers; Sealants, Prefabricated stainless steel crowns; Periodontal services; Basic restorations; Crowns, inlays, onlays; Buildups and post and cores; Fixed partial dentures, full dentures or partial removable dentures; Denture relining, rebasing or adjustments; Pulpal therapy; Root canal; Perialical and occlusal intraoral films; General anesthesia and IV sedation.
29. Orthodontic services, supplies and appliances.
30. For services determined to be furnished as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Health Occupations Article. Prohibited referrals are referrals of a patient to an entity in which the referring dentist, or the dentist's immediate family: (a) owns a beneficial interest; or (b) has a compensation arrangement. The dentist's immediate family includes the spouse, child, child's spouse, parent, spouse's parent, sibling, or sibling's spouse of the dentist, or that dentist in combination.

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. A "benefit accumulation year," as used in this Schedule, means the time period under the Group Contract during which the Plan's Covered Services accrue and is either a calendar year (12 months beginning in January and ending in December) or a contract year (12 months beginning with the Effective Date of the Group Contract).

1. Full mouth x-rays – one (1) every 60 months 5 calendar or contract year(s).
2. Bitewing x-rays – one (1) set(s) per 6 months 1 calendar or contract year(s) under age fourteen (14) and one (1) set(s) per 12 months 1 calendar or contract year(s) age fourteen (14) and older.
3. Oral Evaluations:

- Comprehensive and periodic – one (1) of these services per 120 days. 1 calendar or contract year(s). 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 120 days Detailed problem focused – one (1) per dentist per patient per 120 days per eligible diagnosis.

4. Prophylaxis – one (1) per 120 days One (1) additional for Members under the care of a medical professional during pregnancy.
5. Fluoride treatment – one (1) per 120 days under age nineteen (19).
6. Space maintainers – one (1) per three (3) year period for Members under age nineteen (19) when used to maintain space as a result of prematurely lost teeth 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 36 months 3 calendar or contract year(s) under age sixteen (16) on permanent first and second molars under age eleven (11) on permanent first molars and under age sixteen (16) on permanent second molars.
8. Prefabricated stainless steel crowns – one (1) per tooth per lifetime for Members under age fifteen (15).
9. Periodontal Services:
   - Full mouth debridement – one (1) per twelve (12) months one (1) calendar or contract year(s) lifetime.
   - Periodontal maintenance following active periodontal therapy – two (2) per twelve (12) months one (1) calendar or contract year(s) in addition to routine prophylaxis.
   - Periodontal scaling and root planing – one (1) per twenty-four (24) months two (2) calendar or contract year(s) per area of the mouth.
   - Surgical periodontal procedures – one (1) per twenty-four (24) months two (2) calendar or contract year(s) per area of the mouth.
   - Guided tissue regeneration – one (1) per tooth per lifetime.

10. Replacement of an existing:
    - filling with another filling – not within 24 months 2 calendar or contract year(s) of placement.
    - single crown with another single crown - not within 60 months 5 calendar or contract year(s) of placement.
    - inlay with another inlay, or with a single crown or onlay – not within 60 months 5 calendar or contract year(s) of placement.
    - onlay with another onlay, or with a single crown - not within 60 months 5 calendar or contract year(s) of placement.
    - buildup with another buildup - not within 60 months 5 calendar or contract year(s) of the procedures in this category.
    - post and core with another post and core - not within sixty (60) months five (5) calendar or contract year(s) of placement of any of the procedures in this category.
    - Replacement of natural tooth/teeth in an arch – not within 60 months 5 calendar or contract year(s) of placement 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 1 calendar or contract year(s) of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every 36 months 3 calendar or contract year(s) thereafter.
12. Pulpal therapy – one (1) per eligible tooth per lifetime only when there is no permanent tooth to replace it. 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 twelve (12) months one (1) calendar or contract year(s). Recementation during the first twelve (12) months one (1) calendar or contract year(s) following insertion of any preventive, restorative or prosthodontic service by the same dentist is included in the preventive, restorative or prosthodontic service benefit.
15. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist

choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.

16. Intraoral films:
    - Periapical – four (4) per twelve (12) months one (1) calendar or contract year(s) per dentist if not performed in conjunction with definitive procedure(s).
    - Occlusal – two (2) per twelve (12) months one (1) calendar or contract year(s) under age (8).
17. General anesthesia and IV sedation: a total of sixty 60 minutes per session.