UNITED CONCORDIA® DENTAL

Proposed Dental Benefits for Freedom Now Home Care LLC

Effective Date: 04/01/2019

Benefit Category	F-Plan3W
Class I	**United Concordia's Standard Frequency Limitations**
Exams	2 every 12 months
X-Rays (Bitewings Only)	1 set every 12 months under age 19 and 1 set every 18 months age 19 and over
X-Rays (All Others)	1 every 5 years for Full Mouth and Panoramic X-Rays Limitations may apply to other types of X-rays.
Cleanings; Fluoride Treatment	2 every 12 months; 1 every 12 months under age 14
Sealants	1 per tooth every 3 years to age 16 on permanent first and second molars
Palliative Treatment (Emergency)	2 per 12 months in combination with pulpal debridement
Space Maintainers	1 every 5 years under age 14
Class II	
Basic Restorative	Not within 24 months of previous placement. Includes coverage for posterior resins.
Simple Extractions	*Any frequency (no limitations)*
Repairs of Crowns, Inlays, Onlays, Dentures and Bridges	1 per 36 months
Endodontics	• Pulpal therapy: primary teeth that have no permanent tooth to replace it • Root canal treatment: one per tooth per lifetime
Non-Surgical Periodontics	• Full mouth debridement: 1 per lifetime • Scaling and root planing : 1 per 36 months (per area of mouth) • Periodontal maintenance: 2 every 12 months (in addition to routine prophylaxis following active periodontal therapy)
Surgical Periodontics	Surgical periodontal procedures: 1 per 36 months (per area of mouth) Guided tissue regeneration: 1 per tooth per lifetime
Complex Oral Surgery	May vary by procedure
General Anesthesia	Limited to 60 minutes per session
Class III	
Inlays, Onlays and Crowns	Not within 5 years of previous placement
Prosthetics (Bridges, Dentures)	Not within 5 years of previous placement
Class IV	
Not Applicable	
Dependent Eligibility	
Dependent children covered to age 26.	
Due to state and federal mandates applying to other states, dependent eligibility may differ from that quoted.	
Selected 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%
UCVision	UCVision provides vision benefits for members and simplifies administration by allowing one enrollment, one bill and one point of contact for both your dental and vision plans.

Proposal represents standard plans. Please see https://www.unitedconcordia.com/VariationsfromStandardBenefitPlans for details regarding benefit variations for plans available in your area.

Quote ID: 349861
02/21/2019

UNITED CONCORDIA® DENTAL

Protecting More Than Just Your Smile®

UCVision Benefits Summary

Included With Your Concordia Dental Plan

<table>
<tr><th>In-Network Coverage</th><th>Frequency (once every)</th><th colspan="3">Member Pays</th></tr>
<tr><td colspan="5">Eye Examination</td></tr>
<tr><td>Eye Exam
(with dilation when professionally indicated)</td><td>12 months</td><td colspan="3">$0</td></tr>
<tr><td colspan="5">Frames</td></tr>
<tr><td>Collection</td><td rowspan="2">12 months</td><td>Fashion: $0</td><td>Designer: $0</td><td>Premier: $25</td></tr>
<tr><td>Non-Collection</td><td colspan="3">$0 ($150 allowance, 20% discount on remaining balance[1])</td></tr>
<tr><td colspan="5">Spectacle Lenses</td></tr>
<tr><td>Clear glass or plastic lenses in single vision, bifocal, trifocal or lenticular prescription</td><td>12 months</td><td colspan="3">$0</td></tr>
<tr><td colspan="5">Spectacle Lens Options</td></tr>
<tr><td>Oversize Lenses</td><td rowspan="15">12 months</td><td colspan="3" rowspan="3">$0</td></tr>
<tr><td>Tinting of Plastic Lenses</td></tr>
<tr><td>Scratch-Resistant Coating</td></tr>
<tr><td>Polycarbonate Lenses</td><td colspan="3">$30
($0 for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater)</td></tr>
<tr><td>Ultraviolet Coating</td><td colspan="3">$12</td></tr>
<tr><td>Anti-Reflective Coating (Standard / Premium / Ultra)</td><td colspan="3">$35 / $48 / $60</td></tr>
<tr><td>Progressive Lenses (Standard / Premium)</td><td colspan="3">$50 / $90</td></tr>
<tr><td>Intermediate-Vision Lenses</td><td colspan="3">$30</td></tr>
<tr><td>Blended-Segment Lenses</td><td colspan="3">$20</td></tr>
<tr><td>High-Index Lenses</td><td colspan="3">$55</td></tr>
<tr><td>Polarized Lenses</td><td colspan="3">$75</td></tr>
<tr><td>Photochromic Glass Lenses</td><td colspan="3">$20</td></tr>
<tr><td>Plastic Photosensitive Lenses</td><td colspan="3">$65</td></tr>
<tr><td>Scratch Protection Plan (Single Vision / Multifocal)</td><td colspan="3">$20 / $40</td></tr>
<tr><td colspan="5">Contact Lenses (in lieu of eyeglasses)</td></tr>
<tr><td>Contact Lens Evaluation, Fitting & Follow-up Care</td><td rowspan="2">12 months</td><td colspan="3">Collection: $0
Non-Collection: $0 ($60 allowance, 15% discount on remaining balance*)</td></tr>
<tr><td>Contact Lenses</td><td colspan="3">Collection: $0 (up to 8 boxes)
Non-Collection: $0 ($130 allowance, 15% discount on remaining balance*)</td></tr>
<tr><td colspan="5">Value-Added Features</td></tr>
<tr><td>One-Year Eyeglass Breakage Warranty
Lens123® Membership</td><td rowspan="2"></td><td colspan="3">$0</td></tr>
<tr><td>Laser Vision Correction</td><td colspan="3">Member receives up to 25% discount on provider's usual fee, or 5% discount on advertised specials, whichever is lower</td></tr>
</table>

<table>
<tr><th colspan="2">Out-of-Network Coverage</th><th>Frequency (once every)</th><th>Member Reimbursement</th></tr>
<tr><td colspan="2">Eye Exam</td><td rowspan="7">12 months</td><td>up to $45</td></tr>
<tr><td colspan="2">Frames</td><td>up to $50</td></tr>
<tr><td rowspan="4">Spectacle Lenses</td><td>Single Vision</td><td>up to $40</td></tr>
<tr><td>Bifocal</td><td>up to $60</td></tr>
<tr><td>Trifocal</td><td>up to $80</td></tr>
<tr><td>Lenticular</td><td>up to $90</td></tr>
<tr><td colspan="2">Non-Collection Contact Lenses
(includes evaluation, fitting and follow-up care)</td><td>up to $120</td></tr>
</table>

Representative listing of covered services – certificate of coverage provides a detailed description of benefits. UCVision benefits administered by Davis Vision, Inc. Discounts and value-added features not underwritten by United Concordia Dental.

*Discount does not apply to services or materials from a Walmart or Sam's Club vision center.

EEM-0097-1116-III

Please visit

Unitedconcordia.com

Unitedconcordia.com/vision

for a list of providers

Per Pay rates includes Dental and Vision

Single	**18.49**
Employee + Spouse	**36.65**
Employee + Child(ren)	**34.98**
Family	**57.05**

UNITED CONCORDIA
America's Premier Dental Insurer

ENROLLMENT FORM

For New Enrollment, please complete ALL sections of this form. For Enrollment Changes, please complete the applicable "Type of Activity" change(s) in Section A along with the identification number and employee name in Section B and Section C for dependent changes.

SECTION A: GENERAL INFORMATION

Effective Date (mm/dd/yyyy)
____/____/________

1. TYPE OF PROGRAM

- ☐ **FFS** (Indemnity, Active PPO, Passive PPO - Please Specify)
  - ☐ Concordia Access
  - ☐ Concordia Choice
  - ☐ Concordia Flex
  - ☐ Concordia Preferred
  - ☐ Concordia Select
  - ☐ Other ____________
- ☐ **DHMO** (Please Specify)
  - ☐ Concordia Plus
  - ☐ Other ____________

2. TYPE OF ACTIVITY

- ☐ **New Enrollment**
- ☐ **Cancel Coverage**
  - ☐ Cancel All Coverage (Employee & All Dependents)
  - ☐ Cancel Dependent(s) Only (List dependents to be cancelled)
- ☐ **Change** (Please Specify)
  - ☐ Add Dependent (e.g., spouse, domestic partner, child, etc.)
  - ☐ Change Address
  - ☐ Reinstate Coverage
  - ☐ Change Name
  - ☐ Change Group Number
  - ☐ Change Provider
  - ☐ COBRA
  - ☐ Other ____________

SECTION E: FOR EMPLOYER USE ONLY

EMPLOYER INFORMATION

Employer Name
FREEDOM NOW H.C.

Group Number
__ __ __ __ __ __ __

Sub Group
__ __ __

UCCI Payroll Location
__ __ __ __ __

SECTION B: EMPLOYEE INFORMATION - Please print clearly to expedite your request.

1. Identification Number (For example, Social Security Number)	2. Original Employment Date (mm/dd/yyyy)		
3. Employee Name (Last, First, Middle Initial)	4. Date of Birth	5. Sex	6. Provider Number (DHMO Only)
7. Home Address	City	State	Zip Code

SECTION C: DEPENDENT INFORMATION

Please list the added/cancelled dependents in this section. For more than five dependent children, complete and attach an additional form. If dependent children listed in this section are disabled or full-time students age 19 or over, please see your group administrator for a Dependent Certification Form, which should be completed and returned with the Dental Enrollment Form.

1. Identification Number (For example, Social Security Number)	2. Type	3. Last Name	4. First Name	5. MI	6. Sex	7. Date of Birth	8. Provider Number (DHMO Only)
	Spouse/Domestic Partner						
	Dependent (A)						
	Dependent (B)						
	Dependent (C)						
	Dependent (D)						
	Dependent (E)						

SECTION D: OTHER DENTAL COVERAGE

Do you or your dependent(s) have other Group Dental Coverage? Yes ☐ No ☐
If your answer is yes, please complete the following information.

Policy Holder	Insurance Company	Policy/Identification Number	Effective Date (mm/dd/yyyy)
			___/___/______

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.

Employee Signature ____________ Date ____________

Employer Signature ____________ Phone Number ____________ Date ____________

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