



Highmark Health Insurance Company
BlueEdgeDental Rates*

Concordia Advantage Network - Advantage Out of Network

Valid programs and rates for effective dates of January 1, 2012 through June 1, 2012.

*Rates are guaranteed for 12 months from the effective date, provided the group meets underwriting guidelines.

The rates on this card do not apply to existing United Concordia Dental or BlueEdge Dental groups.

Flex Plans
10-50 Contracts
70%+ Participation

STANDARD OPTION	WFA F-Plan 2W	WFB F-Plan 4W	WFC F-Plan 3W	WFW F-Plan 8W
CLASS I SERVICES				
Exams, Cleanings & Fluoride Treatments	100%	100%	100%	100%
All X-Rays				
Sealants				
Palliative Treatment (Emergency)				
CLASS II SERVICES				
Space Maintainers	80%	100%	80%	100%
Basic Restorative (Fillings, etc.)				
Endodontics				
Repairs (Crowns, Inlays, Onlays, Bridges, Dentures)				
Periodontics (Surgical and Nonsurgical)				
Oral Surgery (including Extractions)				
General Anesthesia				
CLASS III SERVICES				
Inlays, Onlays, Crowns	Not Covered	Not Covered	50%	50%
Prosthetics (Bridges, Dentures)				
ORTHODONTICS (dependent children to age 19)				
Diagnostic, Active, Retention Treatment	Not Covered	Not Covered	Not Covered	Not Covered
DEDUCTIBLES, MAXIMUMS & MINIMUM CONTRACTS				
Calendar Year Maximum	\$1,500	\$1,500	\$1,500	\$1,500
Orthodontic Lifetime Maximum	Not Covered	Not Covered	Not Covered	Not Covered
Minimum Enrolled Contract Count	10	10	10	10
Minimum Participation	70%	70%	70%	70%

WFC F-Plan 3W	WFW F-Plan 8W
100%	100%
80%	100%
50%	50%
50%	50%
\$1,500	\$1,500
\$1,000	\$1,000
10 ^a	10 ^a
70%	70%

WFC F-Plan 3W	WFW F-Plan 8W
100%	100%
80%	100%
50%	50%
50%	50%
\$1,500	\$1,500
\$1,000	\$1,000
25	25
70%	70%

Calendar Year Deductible \$0

Plan ID		PG3FA1	PG3FB1	PG3FC1	PG3FW1
Two-Tier Rates	Employee	\$22.40	\$25.60	\$31.80	\$34.75
	Family	\$69.45	\$78.60	\$90.20	\$97.10
Four-Tier Rates	Employee	\$22.40	\$25.60	\$31.80	\$34.75
	Employee & 1 Adult	\$44.85	\$44.85	\$63.00	\$69.40
	Employee & Child(ren)	\$47.65	\$53.65	\$58.25	\$62.05
	Family	\$76.85	\$87.10	\$97.60	\$104.65

PG3FD1	PG3FX1
\$31.80	\$34.75
\$102.85	\$111.15
\$31.80	\$34.75
\$63.00	\$69.40
\$72.45	\$77.50
\$115.95	\$124.65

PG3FD2	PG3FX2
\$31.80	\$34.75
\$96.65	\$104.15
\$31.80	\$34.75
\$63.00	\$69.40
\$65.35	\$69.75
\$106.75	\$114.65

Calendar Year Deductible \$50/\$150 (Waived for Orthodontics & Class I Services)

Plan ID		PG3FA5	PG3FB5	PG3FC5	PG3FW5
Two-Tier Rates	Employee	\$21.50	\$24.55	\$30.45	\$33.35
	Family	\$66.65	\$75.45	\$85.05	\$93.20
Four-Tier Rates	Employee	\$21.50	\$24.55	\$30.45	\$33.35
	Employee & 1 Adult	\$43.05	\$43.05	\$60.95	\$66.60
	Employee & Child(ren)	\$45.70	\$51.50	\$54.45	\$59.55
	Family	\$73.75	\$83.60	\$92.00	\$100.45

PG3FD5	PG3FX5
\$30.50	\$33.35
\$99.20	\$107.20
\$30.50	\$33.35
\$60.45	\$66.60
\$70.10	\$75.00
\$112.00	\$120.45

PG3FD6	PG3FX6
\$30.50	\$33.35
\$93.00	\$100.20
\$30.50	\$33.35
\$60.45	\$66.60
\$63.00	\$67.25
\$102.85	\$110.40

^aIn 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.

Rates for 20-69.9% participation are stored on a separate rate card.

Valid in the following PA counties: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, Mckean, Mercer, Potter, Somerset, Venango, Warren, Washington, Westmoreland

Highmark Health Insurance Company is an Independent Licensee of the Blue Cross and Blue Shield Association.

Underwriting Guidelines

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

1. All percentages are based upon the selected in-network or out of network 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. Standard Highmark Health Insurance Company policies and procedures and exclusions and limitations apply (refer to Es & Ls included).
6. If the group is multi-state, at least 90% of eligibles are located in the rate card region.
7. This chart is a representative listing of services covered under the proposed program.
8. The overall average number of members per contract is less than 5.
9. Dental plan is not offered in conjunction with another dental plan or another carrier.
10. The group has no claims experience available.
11. All proposed rates assume no change to the proposed benefit design. Highmark Health Insurance Company reserves the right to re-evaluate proposed rates and benefit if any state or federally mandated benefits or fees are imposed.

Highmark Health Insurance Company will not pay commissions to producers who are not appointed.

FFS & PPO Programs

Standard Dental Plans Principal Exclusions

Exclusions and limitations may differ by state. Some exclusions and/or limitations may be waived depending on the Member's medical condition. Only American Dental Association procedure codes are covered.

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

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (e.g. 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 (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 Member 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. For Group Policies issued and delivered in Washington, this exclusion does not apply when required dental services and procedures are performed in a dental office for covered persons under the age of seven (7) or physically or developmentally disabled.
6. Which are Cosmetic in nature as determined by the Company (e.g. bleaching, veneer facings, personalization or characterization of crowns, bridges 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). For Group Policies issued and delivered in Pennsylvania, this exclusion shall not apply to newly born children of Members including newly adoptive children, regardless of age.
9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the Certificate.
10. 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.
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 Member 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 Member or on behalf of the Member 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 Members 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 Members 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 Members 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 bridge by the same dentist is included in the crown or bridge 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. Payment for orthodontic services shall cease at the end of the month after termination by the Company. This limitation does not apply to Group Policies issued and delivered in Maryland.

Renewability, Termination Provisions of the Policy or Group Contract

Highmark Health Insurance Company policies cover dental benefits only. Highmark Health Insurance Company's Group Policy begins on the agreed effective date and renews subject to the terms of the Group Policy. Either the employer/group or Highmark Health Insurance Company may elect not to renew the Group Policy by providing written notice to the other party at least 31 days prior to renewal. Highmark Health Insurance Company may terminate the Group Policy with 31 days written notice if the employer/group fails to pay premium. Highmark Health Insurance Company may adjust rates or benefits or terminate the Policy on any premium due date with 31 days advance notice if the minimum participation requirements are not achieved or the nature of the risk changes significantly.

Employees/members may be subject to open enrollment periods, late enrollment or voluntary disenrollment restrictions, or continuous enrollment to advance benefit level as required by the Group Policy terms. Employees/members must also meet their employer's or group's eligibility requirements or waiting period for insurance. The amount of benefits and cost depend upon the plan selected.

Policy Form: HHIC/DENT/G/RC/EL

Underwritten by Highmark Health Insurance Company.