UNITED CONCORDIA® DENTAL

DHMO Plans

Dental HMO Programs for Pennsylvania Employer Groups with 2–50 Enrolled Contracts

Concordia Plus Network

Valid programs and rates for effective dates of January 1, 2016 through July 1, 2016.
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 groups.

		MEMBER COPAYMENTS		
		PA1620	PA1640	PA1660
ADA PROCEDURE CODE*	ADA DESCRIPTION*	Plan 1620PA	Plan 1640PA	Plan 1660PA
CLINICAL ORAL EVALUATIONS				
D0120	Periodic oral evaluation - established patient	$0	$0	$0
D0140	Limited oral evaluation - problem focused	$0	$0	$0
D0150	Comprehensive oral evaluation - new or established patient	$0	$0	$0
RADIOGRAPHS/DIAGNOSTIC IMAGING				
D0210	Intraoral - complete series (including bitewings)	$0	$0	$0
D0220	Intraoral - periapical first film	$0	$0	$0
D0274	Bitewings - four films	$0	$0	$0
PREVENTIVE				
D1110	Prophylaxis - adult	$0	$0	$0
D1120	Prophylaxis - child	$0	$0	$0
D1208	topical application of fluoride (prophylaxis not included) - child	$0	$0	$0
D1353	Sealant - per tooth	$9	$8	$0
RESTORATIVE				
D2140	Amalgam - one surface, primary or permanent	$25	$13	$0
D2150	Amalgam - two surfaces, primary or permanent	$31	$17	$0
D2330	Resin-based composite - one surface, anterior	$29	$15	$0
D2331	Resin-based composite - two surfaces, anterior	$36	$20	$0
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$45	$25	$0
CROWNS				
D2750	Crown - porcelain fused to high noble metal	$367**	$329**	$298**
ENDODONTIC THERAPY				
D3330	Endodontic therapy, molar (excluding final restoration)	$202	$178	$167
PERIODONTICS				
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$61	$40	$0
D4910	Periodontal maintenance	$35	$32	$0
ORAL SURGERY				
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$26	$16	$0
D7240	Removal of impacted tooth - completely bony	$131	$113	$103
ORTHODONTICS				
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$3,667	$3,454	$3,454

**Current Dental Terminology* © American Dental Association.

**Charges for the use of precious (high noble) or semi precious (noble) metal are not included in the copayment for crowns, bridges, pontics, inlays and onlays. The decision to use those materials is a cooperative effort between the provider and the patient, based on the professional advice of the provider. Providers are expected to charge no more than an additional $125 for these materials.

Comparable benefit under fee-for-service program without deductible or maximum

Services	1620	1640	1660
Class I	100%	100%	100%
Class II	66%	76%	90%
Class III	46%	52%	57%

Above plan payment percentages are for comparison purposes only and are not used in benefit or rate caluclations under a dental HMO program

DHMOTemp072012

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		Southeastern Valid in the following Zip Codes: 189xx-194xx			Western Valid in the following Zip Codes: 150xx -167xx		
Minimum Enrollment & Participation							
Minimum Enrolled		2	2	2	2	2	2
STANDARD PLAN OPTION		PA1520	PA1540	PA1560	PA1520	PA1540	PA1560
Plan ID							
Two-Tier	Employee	$16.50	$17.60	$18.50	$17.40	$18.80	$19.50
	Family	$47.50	$50.80	$53.60	$51.80	$55.95	$58.05
Four-Tier	Employee	$16.50	$17.60	$18.50	$17.40	$18.80	$19.50
	Employee & 1 Adult	$32.80	$34.80	$36.80	$32.80	$35.45	$36.75
	Employee & Child(ren)	$39.20	$41.70	$44.00	$35.55	$38.40	$39.85
	Family	$49.30	$52.50	$55.40	$53.55	$57.90	$60.05

United Concordia Dental DHMO Plans

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

1. Benefits are calculated based on the copayment schedule.
2. Minimum enrollment counts must be achieved and maintained.
3. Spousal waivers count toward participation requirements but are not applicable to the minimum enrollment requirements.
4. Programs assume dependent children are eligible to age 26.
5. Standard United Concordia policies and procedures and exclusions and limitations apply (refer to Es & Ls included).
6. If the group is multi-state, at least 90% pf those eligible 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 conjuction with another dental plan or another carrier.
10. The group has no claims experience available.
11. Rates on this card apply only to new business sold through United Concordia.
12. All proposed rates, guarantess and caps assime no change to the proposed benefit design. United Concordia reserves the right to re-evaluate proposed rates and benefits 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 updated information.

United Concordia will not accept business submitted by or pay commissions to producers who are not appounted. 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.

UNITED CONCORDIA®

United Concordia Standard Exclusions and Limitations for DHMO plans.

Exclusions and limitations may differ by benefit plan. Only American Dental Association procedure codes are covered. In the event of conflict between the Group Contract and this proposal, the Group Contract will govern.

1. Not specifically listed in the Schedule of Benefits as a Covered Service.
2. Provided to Members outside of the office in which the Member is enrolled and which are not pre-authorized by the Company (including specialty care services).
3. Which in the opinion of the treating dentist, or the Company, are not clinically necessary, or do not have a reasonable, favorable prognosis.
4. That are necessary due to lack of cooperation with the treating dentist, or failure to comply with a professionally prescribed Treatment Plan.
5. Started to incurred prior to the Member's eligibility under the Company or after the Termination Date of coverage with the Company.
6. For consultation by a Specialty Care dentist for services not specifically listed on the Schedule of Benefits as a Covered Service.
7. That do not meet accepted standards of dental treatment, which are Experimental to Investigative in nature or are considered enhancements to standard dental treatments as determined by the Company.
8. For hospitalization and associated costs for rendering services in a hospital.
9. Determined by the Company to be the responsibility of Worker's compensation or employer's liability or health care plan, or payable under any federal government or state program, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy, or for services for which benefits are payable under any other insurance policy.
10. For prescription or non-prescription drugs, home care items, vitamins or dietary supplements.
11. Which are principally Cosmetic in nature, including, but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures as determined by the Company.
12. For diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint (TMJ) syndrome and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint.
13. For services and/or appliances that alter the vertical dimension or alter, restore or maintain thee occlusion, including, but not limited to, full moth rehabilitation, splinting, appliances or any other method.
14. That restore tooth structure lost due to attrition, erosion or abrasion.
15. For replacement of lost, missing, stolen or damaged prosthetic device or orthodontic appliance or for duplicate dentures, prosthetic devices or any duplicative device.
16. For the following, which are not included as orthodontic benefits, retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient non-cooperation, repair of orthodontic appliances, replacement of lost or stolen appliances, special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders), myofunctional therapy, cases involving orthognathic surgery, extractions for orthodontic purposes, and treatment in excess of twenty-four months.
17. For implants, surgical insertion and/or removal of, and any appliances and/or prosthetics attached to implants.
18. Required because of, or in connection with, acts of war, declared or undeclared.
19. For elective procedures, including, but not limited to, prophylactic extractions of third molars.

Limitations:

The following services will be subject to Limitations as set forth below:

1. Referral to a Specialty Care Dentist is limited to orthodontics, oral surgery, periodontics, endodontics, and pediatric dentists.
2. Coverage for referral to a pediatric Specialty Care Dentist ends on a Member's 7th birthday. However, exceptions for physical or mental handicaps or medically compromised children, when confirmed by a physician, may be considered on an individual basis with prior approval from the Company. 3. Member must remain in the Plan during the period of time they are undergoing orthodontic treatment. Any early termination can result in additional charges for all unfinished work. This limitation only applies to subscriber termination, not group termination.
4. Sealants - one (1) per tooth per three (3) year period through age ten (10) on permanent first molars and through age fifteen (15) on permanent second molars.
5. In the case a Dental Emergency involving pain or a condition requiring immediate treatment occurring more than fifty (50) miles from the Member's home, the Plan covers necessary diagnostic and therapeutic dental procedures administered by a dentist up to a maximum of $100 for each emergency visit.
6. Periodontal maintenance following active periodontal therapy – two (2) per twelve (12) consecutive months in combination with routine prophylaxis.
7. Periodontal scaling and root planing - one (1) per twenty-four (24) consecutive month period per area of the mouth.
8. Surgical periodontal procedures - one (1) per thirty-six (36) consecutive month period per area of the mouth.
9. Root canal retreatment - one (1) per tooth per lifetime.
10. Panoramic or full mouth x-rays - one (1) every three (3) years.
11. One (1) set of bitewing x-rays per six (6) consecutive months.
12. Prophylaxis - one (1) per six (6) consecutive months, unless otherwise specified in the Schedule of Benefits.
13. Fluoride treatment - one (1) per six (6) consecutive months through age eighteen (18).
14. Crown lengthening - one (1) per tooth per lifetime.
15. Denture relining or rebasing - integral if provided within six (6) months of insertion by the same dentist. This limitation does not apply to immediate dentures.
16. Subsequent denture relining or rebasing - limited to one (1) every thirty-six (36) consecutive months thereafter.
17. Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bony or complete bony impactions).