HIGHMARK. | Blue Edge Dental

Dental Programs for Central PA Employer Groups with 2-50 Enrolled Contracts

Valid programs and rates for effective dates of July 1, 2023 through December 1, 2023. 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 or Blue Edge Dental groups.**

FFS PRODUCTS		Flex	Flex	Flex	Flex	Flex	Preferred	
							Network	Non-Network
DENTAL PLAN OPTION		F-2W	F-3W	F-3Wo	F-4W	F-8W	P-10Wo	
NETWORK								
Network Reimbursement		Advantage	Advantage	Advantage	Advantage	Advantage	Advantage	
Out-of-Network Reimbursement		Advantage	Advantage	Advantage	Advantage	Advantage		Advantage
CLASS I SERVICES								
Exams, Cleanings & Fluoride Treatments All X-Rays Sealants Palliative Treatment (Emergency) Space Maintainers		100%	100%	100%	100%	100%	100%	80%
CLASS II SERVICES								
Basic Restorative (Fillings, etc.) Repairs (Crowns, Inlays, Onlays, Bridges, Dentures) Oral Surgery (including Simple and Surgical Extractions) General Anesthesia Endodontics Periodontics (Surgical and Nonsurgical) Posterior Resins (White Fillings)		80%	80%	80%	100%	100%	80%	60%
CLASS III SERVICES								
Inlays, Onlays, Crowns Prosthetics (Bridges, Dentures)		Not Covered	50%	50%	Not Covered	50%	50%	50%
ORTHODONTICS (dependent children to age 19)								
Diagnostic, Active, Retention Treatment		Not Covered	Not Covered	50%	Not Covered	Not Covered	50%	50%
WAITING PERIODS								
Class I services		None	None	None	None	None	None	None
Class II services		None	None	None	None	None	None	None
Class III services		Not Covered	None	None	Not Covered	None	None	None
Orthodontic services		Not Covered	Not Covered	None	Not Covered	Not Covered	None	None
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	$50/$150	
Orthodontics (dependent children to age 19) Lifetime Maximum		Not Covered	Not Covered	$1,000	Not Covered	Not Covered	$1,000	

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Dental Rates for Central PA Employer Groups with 2-9 Enrolled Contracts

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DENTAL PLAN OPTION		F-2W	F-3W	F-4W	F-8W	P-10Wo
Minimum Enrolled		2	2	2	2	2
Minimum Participation		70%-100%	70%-100%	70%-100%	70%-100%	70%-100%
TWO-TIER RATES						
$1000 Calendar Year Maximum	Employee	20.60	30.00	23.00	32.40	28.60
	Family	50.80	74.00	56.60	79.80	86.60
$1500 Calendar Year Maximum	Employee	21.60	31.50	24.10	34.00	30.00
	Family	53.20	77.60	59.30	83.70	90.20
FOUR-TIER RATES						
$1000 Calendar Year Maximum	Employee	20.60	30.00	23.00	32.40	28.60
	Employee & 1 Adult	39.40	57.60	44.00	62.10	54.60
	Employee & Child(ren)	36.00	52.50	40.10	56.60	66.00
	Family	59.90	87.60	66.90	94.50	99.30
$1500 Calendar Year Maximum	Employee	21.60	31.50	24.10	34.00	30.00
	Employee & 1 Adult	41.30	60.40	46.10	65.20	57.40
	Employee & Child(ren)	37.80	55.00	42.10	59.30	68.40
	Family	62.80	91.80	70.10	99.10	103.40
Minimum Enrolled		2	2	2	2	2
Minimum Participation		20%-69.99%	20%-69.99%	20%-69.99%	20%-69.99%	20%-69.99%
TWO-TIER RATES						
$1000 Calendar Year Maximum	Employee	23.70	34.50	26.40	37.20	32.80
	Family	58.40	85.10	65.10	91.80	99.60
$1500 Calendar Year Maximum	Employee	24.90	36.20	27.70	39.00	34.50
	Family	61.20	89.20	68.20	96.30	103.70
FOUR-TIER RATES						
$1000 Calendar Year Maximum	Employee	23.70	34.50	26.40	37.20	32.80
	Employee & 1 Adult	45.30	66.20	50.50	71.40	62.80
	Employee & Child(ren)	41.40	60.30	46.20	65.10	75.90
	Family	68.90	100.70	76.90	108.70	114.10
$1500 Calendar Year Maximum	Employee	24.90	36.20	27.70	39.00	34.50
	Employee & 1 Adult	47.50	69.40	53.00	74.90	66.00
	Employee & Child(ren)	43.40	63.30	48.40	68.20	78.70
	Family	72.30	105.60	80.60	113.90	118.90

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Dental Rates for Central PA Employer Groups with 10-50 Enrolled Contracts

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DENTAL PLAN OPTION		F-2W	F-3W	F-3Wo*	F-4W	F-8W	P-10Wo*
Minimum Enrolled		10	10	10	10	10	10
Minimum Participation		70%-100%	70%-100%	70%-100%	70%-100%	70%-100%	70%-100%
TWO-TIER RATES							
$1000 Calendar Year Maximum	Employee	19.00	27.60	27.60	21.10	29.70	26.10
	Family	46.70	68.00	80.30	52.00	73.30	76.60
$1500 Calendar Year Maximum	Employee	19.90	28.90	28.90	22.10	31.20	27.50
	Family	48.90	71.30	83.50	54.50	76.80	79.80
FOUR-TIER RATES							
$1000 Calendar Year Maximum	Employee	19.00	27.60	27.60	21.10	29.70	26.10
	Employee & 1 Adult	36.20	52.90	52.90	40.40	57.00	50.00
	Employee & Child(ren)	33.10	48.20	60.30	36.90	52.00	57.70
	Family	55.10	80.40	92.50	61.40	86.70	88.20
$1500 Calendar Year Maximum	Employee	19.90	28.90	28.90	22.10	31.20	27.50
	Employee & 1 Adult	37.90	55.40	55.40	42.30	59.80	52.50
	Employee & Child(ren)	34.70	50.50	62.60	38.70	54.50	60.00
	Family	57.70	84.30	96.40	64.40	90.90	92.00
Minimum Enrolled		10	10	10	10	10	10
Minimum Participation		20%-69.99%	20%-69.99%	20%-69.99%	20%-69.99%	20%-69.99%	20%-69.99%
TWO-TIER RATES							
$1000 Calendar Year Maximum	Employee	21.80	31.70	31.70	24.30	34.20	30.10
	Family	53.70	78.20	92.30	59.80	84.30	88.10
$1500 Calendar Year Maximum	Employee	22.80	33.30	33.30	25.40	35.90	31.60
	Family	56.20	81.90	96.10	62.70	88.40	91.80
FOUR-TIER RATES							
$1000 Calendar Year Maximum	Employee	21.80	31.70	31.70	24.30	34.20	30.10
	Employee & 1 Adult	41.60	60.80	60.80	46.40	65.60	57.50
	Employee & Child(ren)	38.10	55.40	69.30	42.40	59.70	66.40
	Family	63.30	92.40	106.40	70.60	99.70	101.40
$1500 Calendar Year Maximum	Employee	22.80	33.30	33.30	25.40	35.90	31.60
	Employee & 1 Adult	43.60	63.70	63.70	48.70	68.80	60.40
	Employee & Child(ren)	39.90	58.10	72.00	44.40	62.60	69.00
	Family	66.40	96.90	110.90	74.00	104.60	105.80

* 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.

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FFS PRODUCTS	Flex	Flex	Flex	Flex
DENTAL PLAN OPTION	Value 1	Value 2	Value 3	Value 4
NETWORK				
Network Reimbursement	Advantage	Advantage	Advantage	Advantage
Out-of-Network Reimbursement	Advantage	Advantage	Advantage	Advantage
CLASS I SERVICES				
Exams, Cleanings & Fluoride Treatments	100%	80%	100%	100%
All X-Rays				
Sealants				
Palliative Treatment (Emergency)				
Space Maintainers				
CLASS II SERVICES				
Basic Restorative (Fillings, etc.)	0%	50%	50%	50%
Repairs (Crowns, Inlays, Onlays, Bridges, Dentures)				
Simple Extractions				
General Anesthesia				
Posterior Resins (White Fillings)				
CLASS III SERVICES				
Endodontics	0%	20%	0%	20%
Periodontics (Surgical and Nonsurgical)				
Oral Surgery (including Surgical Extractions)				
Inlays, Onlays, Crowns				
Prosthetics (Bridges, Dentures)				
ORTHODONTICS (dependent children to age 19)				
Diagnostic, Active, Retention Treatment	Not Covered	Not Covered	Not Covered	Not Covered
WAITING PERIODS				
Class I services	None	None	None	None
Class II services	None	None	None	None
Class III services	None	None	None	None
Orthodontic services	Not Covered	Not Covered	Not Covered	Not Covered
DEDUCTIBLES & MAXIMUMS				
Calendar Year Deductible (Flex: waived for Class I services) (Preferred: waived for Orthodontic & In-Network Class I services)	$0/$0	$100/$300	$25/$75	$100/$300
Orthodontics (dependent children to age 19) Lifetime Maximum	Not Covered	Not Covered	Not Covered	Not Covered

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Dental Rates for Central PA Employer Groups with 2-9 Enrolled Contracts

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DENTAL PLAN OPTION		Value 1	Value 2	Value 3	Value 4
Minimum Enrolled		2	2	2	2
Minimum Participation		70%-100%	70%-100%	70%-100%	70%-100%
TWO-TIER RATES					
$1000 Calendar Year Maximum	Employee	13.10	15.30	15.60	17.30
	Family	32.60	37.60	38.50	42.50
FOUR-TIER RATES					
$1000 Calendar Year Maximum	Employee	13.10	15.30	15.60	17.30
	Employee & 1 Adult	25.50	29.10	30.10	32.90
	Employee & Child(ren)	23.10	26.70	27.30	30.20
	Family	38.80	44.20	45.80	50.10
Minimum Enrolled		2	2	2	2
Minimum Participation		20%-69.99%	20%-69.99%	20%-69.99%	20%-69.99%
TWO-TIER RATES					
$1000 Calendar Year Maximum	Employee	15.10	17.60	17.90	19.90
	Family	37.50	43.20	44.30	48.90
FOUR-TIER RATES					
$1000 Calendar Year Maximum	Employee	15.10	17.60	17.90	19.90
	Employee & 1 Adult	29.30	33.40	34.70	37.90
	Employee & Child(ren)	26.50	30.70	31.40	34.70
	Family	44.60	50.90	52.70	57.60

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DENTAL PLAN OPTION		Value 1	Value 2	Value 3	Value 4
Minimum Enrolled		10	10	10	10
Minimum Participation		70%-100%	70%-100%	70%-100%	70%-100%
TWO-TIER RATES					
$1000 Calendar Year Maximum	Employee	12.30	14.00	14.40	15.80
	Family	30.60	34.20	35.70	38.70
FOUR-TIER RATES					
$1000 Calendar Year Maximum	Employee	12.30	14.00	14.40	15.80
	Employee & 1 Adult	23.90	26.40	27.90	30.00
	Employee & Child(ren)	21.60	24.30	25.30	27.50
	Family	36.30	40.20	42.40	45.60
Minimum Enrolled		10	10	10	10
Minimum Participation		20%-69.99%	20%-69.99%	20%-69.99%	20%-69.99%
TWO-TIER RATES					
$1000 Calendar Year Maximum	Employee	14.10	16.10	16.60	18.20
	Family	35.20	39.30	41.00	44.50
FOUR-TIER RATES					
$1000 Calendar Year Maximum	Employee	14.10	16.10	16.60	18.20
	Employee & 1 Adult	27.50	30.40	32.10	34.40
	Employee & Child(ren)	24.90	27.90	29.00	31.60
	Family	41.80	46.20	48.80	52.40

Highmark Blue Edge Dental Plans

Underwriting Guidelines

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

1. In-network benefits are calculated using selected networks Maximum Allowable Charge (MAC). Out-of-network benefits are calculated based upon selected networks MAC.
2. Both minimum enrolled contract count and participation requirement must be achieved.
3. Programs assume dependent children are eligible to age 26 and full-time students to age 26. (*Termination will occur first of month following 26th birthdate*)
4. Class I, II and III services are counted toward the Benefit Period maximum.
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 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 conjunction with another dental plan or another carrier.
10. The group has no claims experience available.
11. All proposed rates, guarantees and caps 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 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.

Producers

Highmark Health Insurance Company will not accept business submitted by or pay commissions to producers who are not appointed.

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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.

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.

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 (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. That are the responsibility of Workers' Compensation or employer's liability insurance policy. The Company's benefits would be 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 (for example but not limitation, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).
7. Elective procedures (for example but not limitation, the prophylactic extraction of third molars).
8. 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).
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 (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.
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 (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 (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).
24. 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.
25. Specialized procedures and techniques (for example but not limitation, precision attachments, copings and intentional root canal treatment).
26. Fees for broken appointments.
27. Those specifically listed on the Schedule of Benefits as "Not Covered" or "Plan pays 0%".
28. 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.
29. For prosthetic services (e.g. full or partial dentures or fixed bridges) if such services replace one (1) or more teeth missing prior to Member's eligibility under the Group Policy.

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 calendar year(s).
2. Bitewing x-rays – one (1) set per 12 months under age nineteen (19) and one (1) set per 18 months age nineteen (19) 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 – one (1) per 12 months under age fourteen (14).
6. Space maintainers – one (1) per five (5) year period for Members under age fourteen (14) 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 calendar 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 fourteen (14).
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 planning – one (1) per 36 months per area of the mouth.
   - Surgical periodontal procedures – one (1) per 36 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 24 months of previous placement of any basic restoration.
    - Single crowns, inlays, onlays – not within 5 calendar years of previous placement of any of the procedures in this category.
    - Buildups and post and cores – not within 5 calendar years of previous placement of any of the procedures in this category.
    - Replacement of natural tooth/teeth in an arch – not within 5 calendar years 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 calendar years thereafter.
12. Pulpal therapy – one (1) per primary tooth per lifetime only when there is no permanent tooth to replace it. Eligible teeth limited to primary anterior teeth.
13. Root canal retreatment – one (1) per tooth per lifetime.
14. Recementation – one (1) per 3 calendar years.
    Recementation during the first calendar year following insertion 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. Payment for orthodontic services, if covered, shall cease at the end of the month after termination by the Company.
17. Intraoral films:
    - Periapical – four (4) per 12 months per dentist if not performed in conjunction with definitive procedure(s).
    - Occlusal – two (2) per 12 months under age eight (8).
18. General anesthesia and IV sedation: a total of 60 minutes per session.

Renewability, Termination Provisions of the Policy or Group Contract

For groups of 2-50

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.

Underwritten by Highmark Health Insurance Company