Highmark Blue Cross Blue Shield West Virginia (51-99 enrolled)

BlueEdgeDental Rates*

Advantage *Plus* Network - Advantage Out of Network

Valid programs and rates for effective dates July 1, 2012 through December 1, 2012.
***Rates are guaranteed for 12 months from the effective date, provided the group meets attached underwriting guidelines.**
The rates on this card do not apply to existing United Concordia Dental or BlueEdge Dental groups.

STANDARD OPTION		WVFA1 F-Plan 2W	WVFB1 F-Plan 4W	WVFC1 F-Plan 3W	WVFD1 F-Plan 3W
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%	80%
Basic Restorative (Fillings, etc.)					
Endodontics					
Repairs (Crowns, Inlays, Onlays, Bridges, Dentures)					
Periodontics (Surgical and Nonsurgical)					
Complex Oral Surgery (including Extractions)					
General Anesthesia					
Posterior Resins (White Fillings)					
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	50%
DEDUCTIBLES, MAXIMUMS & MINIMUM CONTRACTS					
Deductible (waived for Orthodontics & Class I Services)		$50/$150	$50/$150	$50/$150	$50/$150
Orthodontic Lifetime Maximum		Not Covered	Not Covered	Not Covered	$1,000
Minimum Enrolled Contract Count		**51**	**51**	**51**	**51**
Minimum Participation		**70%**	**70%**	**70%**	**70%**
$1,000 Calendar Year Maximum					
Two-Tier Rates	Employee	$20.30	$23.00	$29.40	$29.40
	Family	$57.50	$63.85	$74.50	$82.00
Four-Tier Rates	Employee	$20.30	$23.00	$29.40	$29.40
	Employee & 1 Adult	$40.50	$45.60	$58.50	$58.50
	Employee & Child(ren)	$43.00	$47.45	$52.45	$60.95
	Family	$69.70	$77.30	$88.45	$99.10
$1,500 Calendar Year Maximum					
Two-Tier Rates	Employee	$21.10	$23.85	$30.95	$30.95
	Family	$59.75	$66.20	$78.25	$85.80
Four-Tier Rates	Employee	$21.10	$23.85	$30.95	$30.95
	Employee & 1 Adult	$42.00	$47.25	$61.45	$61.45
	Employee & Child(ren)	$44.65	$49.15	$55.20	$63.70
	Family	$72.20	$79.95	$93.00	$103.65

The indicated rates include our Preventive Incentive® program encompassing the following plan features:
- ALL covered Class I services are excluded from the annual plan maximum.
- There is NO waiting until the next plan year to enjoy the feature.
- There is NO need to monitor which services are received or understand paragraphs of fine print.

For additional plan options , please contact your Highmark sales representative.

HIGHMARKWV/DENT/G/RC

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 Blue Cross Blue Shield West Virginia 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. The plans will exclude SICs 6300-6599, 7361, 7389, 7800-7899 and any code 8000 or higher range of codes.
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 must have one year prior dental coverage. (Custom quote available for groups with no prior dental coverage.)
12. All proposed rates assume no change to the proposed benefit design. Highmark Blue Cross Blue Shield West Virginia reserves the right to re-evaluate proposed rates and benefit if any state or federally mandated benefits or fees are imposed.

Highmark Blue Cross Blue Shield West Virginia will not accept business submitted by or pay commissions to producers who are not appointed. Any premium payment or group application submitted to Highmark Blue Cross Blue Shield West Virginia 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 Highmark Blue Cross Blue Shield West Virginia constitutes acceptance of and agreement to comply with this rule. To obtain an appointment packet, visit the Agent Tab of www.highmarkbcbswv.com.

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 Blue Cross Blue Shield West Virginia policies cover dental benefits only. Highmark Blue Cross Blue Shield West Virginia'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 Blue Cross Blue Shield West Virginia may elect not to renew the Group Policy by providing written notice to the other party at least 31 days prior to renewal. Highmark Blue Cross Blue Shield West Virginia may terminate the Group Policy with 31 days written notice if the employer/group fails to pay premium. Highmark Blue Cross Blue Shield West Virginia 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: HIGHMARKWV/G/RC/EL

Underwritten by Highmark Blue Cross Blue Shield West Virginia.