HIGHMARK. Blue Edge Dental

Dental Programs for Northeastern New York Employer Groups with 2-100 Full Time Equivalents (FTEs)

Valid programs and rates for effective dates of January 1, 2024 through December 31, 2024. 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 Blue Edge Dental groups.**

FFS PRODUCTS		Flex	Flex	Flex
DENTAL PLAN OPTION		F-2W	F-3W	F-3Wo
NETWORK				
Network Reimbursement		Elite Prime Northeastern New York (NENY)	Elite Prime Northeastern New York (NENY)	Elite Prime Northeastern New York (NENY)
Out-of-Network Reimbursement		Elite Prime Northeastern New York (NENY)	Elite Prime Northeastern New York (NENY)	Elite Prime Northeastern New York (NENY)
CLASS I SERVICES – Member Cost Share				
Exams, Cleanings & Fluoride Treatments		Covered in full	Covered in full	Covered in full
All X-Rays				
Sealants				
Palliative Treatment (Emergency)				
Space Maintainers				
CLASS II SERVICES – Member Cost Share				
Basic Restorative (Fillings, etc.)		20%	20%	20%
Repairs (Crowns, Inlays, Onlays, Bridges, Dentures)				
Oral Surgery (including Simple and Surgical Extractions)				
General Anesthesia				
Endodontics				
Periodontics (Surgical and Nonsurgical)				
Posterior Resins (White Fillings)				
CLASS III SERVICES – Member Cost Share				
Inlays, Onlays, Crowns		Not Covered	50%	50%
Prosthetics (Bridges, Dentures)				
ORTHODONTICS – Member Cost Share (dependent children to age 19)				
Diagnostic, Active, Retention Treatment		Not Covered	Not Covered	50%
WAITING PERIODS				
Class I services		None	None	None
Class II services		None	None	None
Class III services		Not Covered	None	None
Orthodontic services		Not Covered	Not Covered	None
DEDUCTIBLES & MAXIMUMS				
Calendar Year Deductible (Flex: waived for Class I services)		$50/$150	$50/$150	$50/$150
Orthodontics (dependent children to age 19) Lifetime Maximum		Not Covered	Not Covered	$1,000
Benefit Period Maximum per Member		$1,000	$1,500	$2,000

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Dental Rates for Northeastern New York Employer Groups with 2-100 Full Time Equivalents (FTEs)

Valid programs and rates for effective dates of January 1, 2024 through December 31, 2024. 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 Blue Edge Dental groups.**

Valid in the following Counties: Albany, Clinton, Columbia, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington

Monthly Premium - Age 26

DENTAL PLAN OPTION	F-2W	F-3W	F-3Wo
Subscriber	$20.39	$26.23	$28.61
Subscriber and Spouse/Domestic Partner	$37.88	$49.56	$54.32
Subscriber and Child(ren)	$46.52	$61.08	$73.16
Family	$69.24	$91.38	$109.41

Monthly Premium - Age 30

DENTAL PLAN OPTION	F-2W	F-3W	F-3Wo
Subscriber	$20.39	$26.23	$28.61
Subscriber and Spouse/Domestic Partner	$37.88	$49.56	$54.32
Subscriber and Child(ren)	$46.66	$61.27	$73.37
Family	$69.46	$91.67	$109.74

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 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 every calendar year.
     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) every calendar year.
5. Fluoride treatment – one (1) every calendar year 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 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) every calendar year 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 years of previous placement of any of the procedures in this category.
    - Buildups and post and cores – not within 5 years of previous placement of any of the procedures in this category.
    - Replacement of natural tooth/teeth in an arch – not within 5 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 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 24 months under age eight (8).
18. General anesthesia and IV sedation: a total of 60 minutes per session.