HIGHMARK. | Blue Edge Dental

Dental Programs for Western PA Employer Groups with 2-9 Enrolled Contracts

Valid programs and rates for effective dates of January 1, 2024 through June 1, 2024. 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-3C**	**F-4W**	**F-8W**	**P-10Wo**	
NETWORK							
Network Reimbursement	Advantage or Advantage Plus	Advantage or Advantage Plus	Advantage or Advantage Plus	Advantage or Advantage Plus	Advantage or Advantage Plus	Advantage or Advantage Plus	
Out-of-Network Reimbursement	Advantage	Advantage	Advantage	Advantage	Advantage		Advantage
CLASS I SERVICES							
Exams, Cleanings & Fluoride Treatments	100%	100%	100%	100%	100%	100%	80%
All X-Rays							
Sealants							
Palliative Treatment (Emergency)							
Space Maintainers							
CLASS II SERVICES							
Basic Restorative (Fillings, etc.)	80%	80%	50% Endodontics & Periodontics 80% All Other Listed Services	100%	100%	80%	60%
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							
Inlays, Onlays, Crowns	Not Covered	50%	50%	Not Covered	50%	50%	50%
Prosthetics (Bridges, Dentures)							
ORTHODONTICS (dependent children to age 19)							
Diagnostic, Active, Retention Treatment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	50%	50%
DEDUCTIBLES & MAXIMUMS							
Calendar Year Deductible (Flex: waived for Ortho & Class I services) (Preferred: waived for Ortho & In-Network Class I services)	$50/$150	$50/$150	$0/$0	$50/$150	$50/$150	$50/$150	
Orthodontics (dependent children to age 19) Lifetime Maximum	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	$1,000	

Waiting periods do not apply to these plans.

Benefits may be provided by or through the following entities which are independent licensees of the Blue Cross Blue Shield Association: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield or Highmark Health Insurance Company. United Concordia is a separate company that administers Highmark dental benefits.

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Dental Rates for Western PA Employer Groups with 2-9 Enrolled Contracts – Advantage Network

Valid programs and rates for effective dates of January 1, 2024 through June 1, 2024. 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.**

Valid in the following Counties: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre, Clearfield, Elk, Fayette, Greene, Huntingdon, Indiana, Jefferson, Lawrence, Potter, Somerset, Washington, Westmoreland

DENTAL PLAN OPTION		F-2W	F-3W	F-3C	F-4W	F-8W	P-10Wo
Minimum Enrolled		2	2	2	2	2	2
Minimum Participation		70%-100%	70%-100%	70%-100%	70%-100%	70%-100%	70%-100%
Network		Advantage	Advantage	Advantage	Advantage	Advantage	Advantage
TWO-TIER RATES							
$1000 Calendar Year Maximum	Employee	19.60	28.60	30.30	21.90	30.80	27.10
	Family	51.30	74.80	79.00	57.20	80.70	87.40
$1500 Calendar Year Maximum	Employee	20.60	30.00	31.60	22.90	32.30	28.50
	Family	53.80	78.40	82.50	59.90	84.60	91.00
$2000 Calendar Year Maximum	Employee	21.20	30.90	32.40	23.60	33.30	29.40
	Family	55.40	80.80	84.70	61.80	87.20	93.30
FOUR-TIER RATES							
$1000 Calendar Year Maximum	Employee	19.60	28.60	30.30	21.90	30.80	27.10
	Employee & 1 Adult	38.60	56.50	59.80	43.10	60.90	53.50
	Employee & Child(ren)	35.20	51.20	54.30	39.20	55.20	64.70
	Family	58.60	85.60	90.80	65.40	92.40	97.30
$1500 Calendar Year Maximum	Employee	20.60	30.00	31.60	22.90	32.30	28.50
	Employee & 1 Adult	40.50	59.20	62.50	45.20	63.90	56.20
	Employee & Child(ren)	36.80	53.70	56.60	41.10	57.90	67.10
	Family	61.40	89.80	94.70	68.50	96.80	101.40
$2000 Calendar Year Maximum	Employee	21.20	30.90	32.40	23.60	33.30	29.40
	Employee & 1 Adult	41.80	61.00	64.20	46.60	65.90	58.00
	Employee & Child(ren)	38.00	55.30	58.20	42.30	59.70	68.70
	Family	63.30	92.50	97.30	70.60	99.80	104.10
Minimum Enrolled		2	2	2	2	2	2
Minimum Participation		20%-69.99%	20%-69.99%	20%-69.99%	20%-69.99%	20%-69.99%	20%-69.99%
Network		Advantage	Advantage	Advantage	Advantage	Advantage	Advantage
TWO-TIER RATES							
$1000 Calendar Year Maximum	Employee	22.60	32.90	34.80	25.10	35.40	31.20
	Family	59.00	86.00	90.90	65.70	92.80	100.50
$1500 Calendar Year Maximum	Employee	23.70	34.40	36.30	26.40	37.10	32.70
	Family	61.80	90.20	94.80	68.90	97.30	104.60
$2000 Calendar Year Maximum	Employee	24.40	35.50	37.30	27.20	38.30	33.80
	Family	63.70	92.90	97.40	71.00	100.30	107.30

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FOUR-TIER RATES								
$1000 Calendar Year Maximum	Employee		22.60	32.90	34.80	25.10	35.40	31.20
	Employee & 1 Adult		44.40	64.90	68.80	49.60	70.10	61.60
	Employee & Child(ren)		40.40	58.90	62.40	45.00	63.50	74.40
	Family		67.40	98.40	104.40	75.10	106.20	111.90
$1500 Calendar Year Maximum	Employee		23.70	34.40	36.30	26.40	37.10	32.70
	Employee & 1 Adult		46.60	68.10	71.80	52.00	73.50	64.70
	Employee & Child(ren)		42.40	61.70	65.10	47.20	66.60	77.20
	Family		70.60	103.20	108.90	78.80	111.40	116.60
$2000 Calendar Year Maximum	Employee		24.40	35.50	37.30	27.20	38.30	33.80
	Employee & 1 Adult		48.00	70.20	73.80	53.60	75.70	66.70
	Employee & Child(ren)		43.60	63.60	66.90	48.60	68.60	79.10
	Family		72.80	106.40	111.90	81.20	114.80	119.70

HIGHMARK. | Blue Edge Dental

Dental Rates for Western PA Employer Groups with 2-9 Enrolled Contracts – Advantage Plus Network

Valid programs and rates for effective dates of January 1, 2024 through June 1, 2024. 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.**

Valid in the following Counties: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre, Clearfield, Elk, Fayette, Greene, Huntingdon, Indiana, Jefferson, Lawrence, Potter, Somerset, Washington, Westmoreland

DENTAL PLAN OPTION		F-2W	F-3W	F-3C	F-4W	F-8W	P-10Wo
Minimum Enrolled		2	2	2	2	2	2
Minimum Participation		70%-100%	70%-100%	70%-100%	70%-100%	70%-100%	70%-100%
Network		Advantage Plus	Advantage Plus	Advantage Plus	Advantage Plus	Advantage Plus	Advantage Plus
TWO-TIER RATES							
$1000 Calendar Year Maximum	Employee	20.00	29.20	30.80	22.30	31.40	27.70
	Family	52.30	76.30	80.50	58.30	82.30	88.90
$1500 Calendar Year Maximum	Employee	21.00	30.60	32.10	23.40	33.00	29.10
	Family	54.90	80.00	84.00	61.10	86.30	92.50
$2000 Calendar Year Maximum	Employee	21.60	31.50	33.00	24.10	34.00	30.00
	Family	56.50	82.50	86.30	63.00	89.00	94.90
FOUR-TIER RATES							
$1000 Calendar Year Maximum	Employee	20.00	29.20	30.80	22.30	31.40	27.70
	Employee & 1 Adult	39.40	57.60	60.90	44.00	62.20	54.70
	Employee & Child(ren)	35.90	52.20	55.30	40.00	56.30	65.70
	Family	59.80	87.40	92.40	66.70	94.30	99.00
$1500 Calendar Year Maximum	Employee	21.00	30.60	32.10	23.40	33.00	29.10
	Employee & 1 Adult	41.30	60.40	63.60	46.10	65.20	57.40
	Employee & Child(ren)	37.60	54.80	57.70	41.90	59.10	68.20
	Family	62.70	91.60	96.50	69.90	98.80	103.20
$2000 Calendar Year Maximum	Employee	21.60	31.50	33.00	24.10	34.00	30.00
	Employee & 1 Adult	42.60	62.30	65.40	47.50	67.20	59.30
	Employee & Child(ren)	38.70	56.40	59.20	43.20	60.90	69.90
	Family	64.60	94.40	99.10	72.10	101.90	106.00
Minimum Enrolled		2	2	2	2	2	2
Minimum Participation		20%-69.99%	20%-69.99%	20%-69.99%	20%-69.99%	20%-69.99%	20%-69.99%
Network		Advantage Plus	Advantage Plus	Advantage Plus	Advantage Plus	Advantage Plus	Advantage Plus
TWO-TIER RATES							
$1000 Calendar Year Maximum	Employee	23.00	33.50	35.40	25.70	36.20	31.80
	Family	60.20	87.80	92.50	67.10	94.70	102.20
$1500 Calendar Year Maximum	Employee	24.10	35.10	37.00	26.90	37.90	33.40
	Family	63.10	92.00	96.60	70.30	99.30	106.40
$2000 Calendar Year Maximum	Employee	24.90	36.20	38.00	27.70	39.10	34.50
	Family	65.00	94.80	99.20	72.50	102.30	109.20

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FOUR-TIER RATES								
$1000 Calendar Year Maximum	Employee		23.00	33.50	35.40	25.70	36.20	31.80
	Employee & 1 Adult		45.30	66.30	70.10	50.60	71.50	62.90
	Employee & Child(ren)		41.20	60.10	63.50	46.00	64.80	75.60
	Family		68.80	100.50	106.30	76.70	108.40	113.90
$1500 Calendar Year Maximum	Employee		24.10	35.10	37.00	26.90	37.90	33.40
	Employee & 1 Adult		47.50	69.50	73.10	53.00	75.00	66.00
	Employee & Child(ren)		43.20	63.00	66.30	48.20	67.90	78.40
	Family		72.10	105.30	110.90	80.40	113.70	118.70
$2000 Calendar Year Maximum	Employee		24.90	36.20	38.00	27.70	39.10	34.50
	Employee & 1 Adult		49.00	71.60	75.20	54.70	77.30	68.10
	Employee & Child(ren)		44.50	64.90	68.10	49.60	70.00	80.30
	Family		74.30	108.60	114.00	82.90	117.20	121.90

HIGHMARK. | Blue Edge Dental

Dental Programs for Western PA Employer Groups with 2-9 Enrolled Contracts

Valid programs and rates for effective dates of January 1, 2024 through June 1, 2024. 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
DENTAL PLAN OPTION	Value 1	Value 2	Value 3	Value 4
NETWORK				
Network Reimbursement	Advantage or Advantage Plus	Advantage or Advantage Plus	Advantage or Advantage Plus	Advantage or Advantage Plus
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
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

Waiting periods do not apply to these plans.

HIGHMARK. | Blue Edge Dental

Dental Rates for Western PA Employer Groups with 2-9 Enrolled Contracts – Advantage Network

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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%
Network		Advantage	Advantage	Advantage	Advantage
TWO-TIER RATES					
$1000 Calendar Year Maximum	Employee	12.60	14.50	14.90	16.40
	Family	32.90	38.00	38.90	43.00
FOUR-TIER RATES					
$1000 Calendar Year Maximum	Employee	12.60	14.50	14.90	16.40
	Employee & 1 Adult	25.10	28.40	29.60	32.20
	Employee & Child(ren)	22.70	26.00	26.70	29.40
	Family	38.10	43.10	44.90	48.80
Minimum Enrolled		2	2	2	2
Minimum Participation		20%-69.99%	20%-69.99%	20%-69.99%	20%-69.99%
Network		Advantage	Advantage	Advantage	Advantage
TWO-TIER RATES					
$1000 Calendar Year Maximum	Employee	14.50	16.70	17.10	18.90
	Family	37.80	43.70	44.70	49.40
FOUR-TIER RATES					
$1000 Calendar Year Maximum	Employee	14.50	16.70	17.10	18.90
	Employee & 1 Adult	28.90	32.70	34.10	37.10
	Employee & Child(ren)	26.00	29.90	30.70	33.80
	Family	43.80	49.60	51.60	56.20

HIGHMARK. | Blue Edge Dental

Dental Rates for Western PA Employer Groups with 2-9 Enrolled Contracts – Advantage Plus Network

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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%
Network		Advantage Plus	Advantage Plus	Advantage Plus	Advantage Plus
TWO-TIER RATES					
$1000 Calendar Year Maximum	Employee	12.80	14.90	15.20	16.80
	Family	33.40	38.90	39.60	44.00
FOUR-TIER RATES					
$1000 Calendar Year Maximum	Employee	12.80	14.90	15.20	16.80
	Employee & 1 Adult	25.50	29.10	30.20	33.00
	Employee & Child(ren)	23.00	26.60	27.20	30.00
	Family	38.70	44.10	45.70	50.00
Minimum Enrolled		2	2	2	2
Minimum Participation		20%-69.99%	20%-69.99%	20%-69.99%	20%-69.99%
Network		Advantage Plus	Advantage Plus	Advantage Plus	Advantage Plus
TWO-TIER RATES					
$1000 Calendar Year Maximum	Employee	14.70	17.10	17.40	19.30
	Family	38.40	44.70	45.60	50.50
FOUR-TIER RATES					
$1000 Calendar Year Maximum	Employee	14.70	17.10	17.40	19.30
	Employee & 1 Adult	29.40	33.50	34.70	37.90
	Employee & Child(ren)	26.50	30.50	31.20	34.50
	Family	44.50	50.70	52.60	57.40

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.

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 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.

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