



**PENNSYLVANIA STATE SYSTEM OF HIGHER EDUCATION
MANAGEMENT BENEFITS PROGRAM
DENTAL BENEFITS**

SCHEDULE OF BENEFITS (CondordiaFLEX)		
BENEFIT	COVERAGE % OF MAXIMUM ALLOWABLE CHARGE	LIMITATIONS
Diagnostic and Preventive		
• Routine oral examinations	100%	Twice per 12 month period
• Full mouth x-rays	100%	Once every 36 months
• Bitewing x-rays	100%	Once every 6 months
• Periapical x-rays	100%	No limitation
• Prophylaxis (teeth cleaning)	100%	Twice per 12 month period
• Topical fluoride application	100%	Once every 6 months; for dependent children under age 19
• Sealants	100%	Once every 36 months on same tooth; for dependent children through age 13
• Space Maintainers	100%	Eligible for dependent children under age 19 when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars
Basic Services		
• Minor restorations – amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations	100%	
• Endodontics, including root canal therapy, pulpotomy, and direct pulp capping	100%	Incomplete endodontic therapy is not covered Pupal therapy is limited to once per tooth per lifetime
• Non-surgical periodontics <ul style="list-style-type: none"> ○ Diagnosis and treatment planning including periodontal examination ○ Periodontal scaling and root planning and special periodontal appliances ○ Maintenance – post treatment preventive periodontal procedures (periodontal prophylaxis) 	100%	Post treatment preventive periodontal procedures are limited to 4 in any period of 12 consecutive months. This maximum will be reduced by the number of routine prophylaxis received during that 12-month period so that the total number of prophylaxis for a given 12-month period, including both routine and periodontal prophylaxis will not exceed 4
• Surgical periodontics	100%	

BENEFIT	COVERAGE % OF MAXIMUM ALLOWABLE CHARGE	LIMITATIONS
Basic Services (cont'd)		
<ul style="list-style-type: none"> • Simple extractions 	100%	
<ul style="list-style-type: none"> • Oral surgery <ul style="list-style-type: none"> ○ Surgical removal of teeth ○ Surgical removal of maxillary or mandibular intrabony cysts ○ Procedures performed for the preparation of the mouth for dentures ○ Apicoectomy (surgical removal of the end of a root) ○ Complete bony impactions ○ Services of a dentist who actively assists the operating surgeon in the performance of covered surgery when the condition of the patient or the type of surgery performed requires assistance 	100%	If more than one surgical procedure is performed by the same dentist during the same operative session, United Concordia will pay 100% UCR for the highest paying procedure and no allowance will be made for additional procedures except where United Concordia deems that an additional allowance is warranted
<ul style="list-style-type: none"> • Anesthesia 	100%	In connection with covered services when rendered by or under the direct supervision of a dentist other than the surgeon, assistant surgeon or attending dentist. The administration of a local infiltration, block anesthetic or use of nitrous oxide as a local anesthetic is not covered
<ul style="list-style-type: none"> • Repair of broken partial or full removable dentures 	80%	
<ul style="list-style-type: none"> • Repair of broken crowns, inlays, onlays or bridges 	80%	
<ul style="list-style-type: none"> • Relining or rebasing of dentures 	70%	More than 6 months after the insertion of an initial or replacement denture, but not more than one relining or rebasing in any period of 36 consecutive months
<ul style="list-style-type: none"> • Palliative emergency treatment of an acute condition requiring immediate care 	100%	
<ul style="list-style-type: none"> • Inpatient consultations, if condition requires it and the dentist in charge of the case requests the consultation 	100%	Limited to one consultation per consultant during any one inpatient stay.
Major Restorative		
<ul style="list-style-type: none"> • Initial insertion of bridges including pontics and abutment crowns, inlays and onlays 	70%	
<ul style="list-style-type: none"> • Initial insertion of partial or full dentures including any adjustments during the 6-month period following insertion 	70%	
<ul style="list-style-type: none"> • Replacement of an existing partial or full denture or bridge by a new denture or by a new bridge 	70%	Only if satisfactory evidence is presented that: <ul style="list-style-type: none"> ○ The existing denture or bridge was inserted at least 5 years prior to the replacement, and ○ The existing denture or bridge is unserviceable and cannot be made serviceable

BENEFIT	COVERAGE % OF MAXIMUM ALLOWABLE CHARGE	LIMITATIONS
Major Restorative (cont'd.)		
<ul style="list-style-type: none"> Single unconnected crowns, inlays and onlays, none of which is part of a bridge or splinted together 	70%	
<ul style="list-style-type: none"> Replacement of crowns, inlays and onlays 	70%	Only if satisfactory evidence is presented that: <ul style="list-style-type: none"> At least 5 years have elapsed since the date of the insertion of the existing crown, inlay or onlay, and Only if the existing crown, inlay or onlay is unserviceable and cannot be serviceable
<ul style="list-style-type: none"> Addition of teeth to an existing partial denture or bridge 	70%	Only if satisfactory evidence is presented that the addition of teeth is required to replace one or more teeth extracted after the existing denture or bridge was inserted
Orthodontics		
<ul style="list-style-type: none"> Diagnosis, including radiographs Active treatment, including necessary appliances Retention treatment following active treatment 	60%	Available to employees and dependents
A treatment plan must be submitted to United Concordia by a dentist with the diagnosis indicating that the orthodontic condition consists of a handicapping malocclusion which is abnormal and is correctable.		
Any charges for the replacement and/or repair of any appliance furnished under the treatment plan or for any duplicate device or appliance will not be paid by United Concordia.		
Functional/myofunctional therapy is covered only when provided by a dentist in conjunction with appliance therapy.		
Deductibles and Maximums		
No Deductible		
\$1,250 maximum benefit per calendar year per person		
\$3,000 Orthodontic lifetime maximum benefit per person		

Predetermination
Predetermination is used by United Concordia to determine eligibility of the patient and to review the treatment plan to determine the extent of coverage. This assures the patient and the dentist that the particular service that will be performed is a covered service. Predetermination is requested for:
<ul style="list-style-type: none"> The extraction of 6 or more teeth; Prosthetics; Crown, Inlay or Onlay restorations; Periodontics; and All treatment plans of \$150 or more
Predetermination is required for:
<ul style="list-style-type: none"> Orthodontics

Participating Dentists accept the Maximum Allowance Charge as payment in full;
Member is responsible for any coinsurance and amounts exceeding the maximum benefit annually.

This exhibit provides only general information. More detailed information about benefits and eligibility are contained in the Plan Document. If there is a difference between this summary and the Plan Document, the Plan Document will govern.

December, 2005