



United Concordia Dental Plans through CBBT

| | Concordia Flex Low | Concordia Plus* ³ | Concordia Preferred | |
|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------|----------------|
| | 2599890000 | 251264000 | 259991000 | |
| Diagnostic Services | | In-Network Only | In-Network | Out-of-Network |
| Routine oral exams (one every 6 months) | 100% | 100% | 100% | 80% |
| Dental x-rays | | | | |
| Full mouth: 1 every 5 years | | | | |
| Bite-wing: 1/6 (<age 14); 1/12 (age 14+) | | | | |
| Periapical: as required | | | | |
| Preventive Services | | In-Network Only | In-Network | Out-of-Network |
| Routine prophylaxis: 2 / 12 months Topical fluoride application ¹ Space maintainers ¹ Sealants | 100% | See Copay Schedule | 100% | 80% |
| Minor Restorations | | In-Network Only | In-Network | Out-of-Network |
| Filling ² | 100% | See Copay Schedule | 80% | 60% |
| Other Services | | In-Network Only | In-Network | Out-of-Network |
| Simple extractions | 100% | See Copay Schedule | 80% | 60% |
| Endodontics | 100% | See Copay Schedule | 80% | 60% |
| Oral Surgery | Not Covered | See Copay Schedule | 80% | 60% |
| Periodontal: Non-Surgical | Not Covered | See Copay Schedule | 80% | 60% |
| Repair of Dentures | Not Covered | See Copay Schedule | 80% | 60% |
| Periodontal: Surgical | Not Covered | See Copay Schedule | 50% | 30% |
| New Dentures | Not Covered | See Copay Schedule | 50% | 30% |
| Inlays, Onlays & Crowns | Not Covered | See Copay Schedule | 50% | 30% |
| Fixed Bridges | Not Covered | See Copay Schedule | 50% | 30% |
| Orthodontics (child only) | | In-Network Only | In-Network | Out-of-Network |
| Orthodontics ⁴ | Not Covered | See Copay Schedule | 50% | |
| Deductibles & Plan Maximums | | In-Network Only | In-Network | Out-of-Network |
| Deductible | None | None | None | |
| Calendar Year Maximum | \$1,000 | N/A | \$1,000 | |
| Orthodontic Lifetime Maximum | N/A | N/A | \$800 | |
| Monthly Rates | Concordia Advantage Network Concordia Flex Low | Concordia Plus Network Concordia Plus | Concordia Advantage Network Concordia Preferred | |
| Individual | \$20.84 | \$20.72 | \$37.58 | |
| Family | \$64.31 | \$60.39 | \$109.65 | |

DISCONTINUED

| Concordia Flex High * |
|-----------------------------------------------------------|
| 259990000 |
| Diagnostic Services |
| 100% |
| Preventive Services |
| 100% |
| Minor Resorations |
| 100% |
| Other Services |
| 100% |
| 100% |
| 100% |
| 50% |
| 50% |
| 50% |
| 50% |
| 50% |
| 50% |
| 50% |
| Orthodontics |
| 50% |
| Deductibles & Maximums |
| None |
| \$1,000 |
| \$800 |
| Concordia Advantage Network Concordia Flex High |
| \$30.67 |
| \$89.43 |

*Payment for services is based on Usual, Customary & Reasonable (UCR) allowances. Please refer to benefit plan description for specific coverage.

¹Coverage is provided to dependent children under certain age limits.

²Only amalgam, silicate, synthetic porcelain or composite restorations.

³All covered services are eligible only when provided by the Primary Dentist within a Concordia Plus Primary Dental Office.

Concordia Plus is only valid for care received in the state of PA by your primary care dentist or an authorized referral.

⁴Dependent children to age 19.