

BENEFIT CATEGORY	ConcordiaFLEX PPO*	ConcordiaPLUS DHMO**
<b>Deductibles</b>	\$50/Person; Maximum - \$100 Family (Applies to all eligible services)	None
<b>Diagnostic and Preventive Services</b>		
Dental Examinations	100%; once in any 6 consecutive months	100% without limitation, as required
Oral Prophylaxis (teeth cleaning)	100%; once in any 6 consecutive months	100% without limitation, as required
Fluoride Application (to age 19)	100%	100%
Oral hygiene counseling	Not Covered	100%
Nutritional counseling	Not Covered	100%
Full Mouth X-rays	100%; once in any 36 consecutive months	100% without limitation, as required
Bitewing X-rays	100%; once in any 6 consecutive months	100% without limitation, as required
Sealants (to age 15; posterior teeth)	Not Covered	100%
<b>Restorative Services</b> (under local anesthesia)		
Basic Restorative Services (silver and tooth-colored fillings) Single unconnected inlays, onlays, and crowns	100%	100%
	75%	80%
<b>Oral Surgery</b> (under local anesthesia) Simple Extractions Most Other Oral Surgery	100%	100%
	100%	80%
<b>Endodontics</b> (under local anesthesia)		
Root Canal Treatment	75%	100%
Apicoectomy	75%	100%
<b>Periodontics – Gum Treatment</b> (under local anesthesia)	Maximum: \$1,500/person/lifetime	
Non-Surgical	75%	80%
Surgical	75%	80%
<b>Fixed Prosthetics</b>		
Fixed Bridgework, including abutment inlays, onlays, crowns and pontics Replacement	75%	80%
	if at least 5 years since initial installation date; subject to contract limitations	
Repairs to Fixed Bridges	75%	80% without limitation, as required
<b>Removable Prosthetics</b>		
Full or Partial Dentures Replacement	75%	80%
	75% if at least 5 years since initial installation date; subject to limitations	80%, without limitation, as required
Relining or Rebased	75%	80%, without limitation, as required
Repairs to Removable Prosthetics	75%	80%
<b>Orthodontics (all members)</b>	75%	60%
	\$750/person/course of treatment	No Lifetime Program Maximum
<b>Out-of-Area Emergency Services</b>	Covered	Up to \$30 reimbursement for each occurrence
<b>CONTRACT YEAR MAXIMUM</b>	\$1,250 per person	None
Maximum applies to	All services except for Diagnostic and Preventive	N/A

\*Plan pays based on United Concordia's Maximum Allowable Charges (MAC). Participating dental providers in the Advantage Plus dental network accept the MAC as payment in full less any member deductibles and coinsurance.

\* Diagnostic and Preventive Services do not count towards the program annual maximum.

\*\*All services under the Concordia PLUS program must be received in or coordinated through a Concordia PLUS Primary Dental Office. Any services not received in or coordinated through the Primary Dental Office will be the patient's financial responsibility. Please refer to your **Concordia PLUS** Co-pay Schedule to determine which procedures are covered and your specific copayment responsibility. The percentages reflected above for this plan are approximate figures. [Concordia PLUS Dental Network-Concordia PLUS](#)