Hometown Health

United Concordia dental

Dental Programs for Nevada Employer Groups with 2-50 Enrolled Contracts

Valid programs and rates for effective dates of July 1, 2026 through December 31, 2026.
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 groups.

FFS PRODUCTS	Flex	Flex	Preferred		Preferred		Preferred	
UNITED CONCORDIA DENTAL PLAN OPTION	**2-50**	**10-50**	**2-50**		**2-50**		**2-50**	
Standard Plan Option	**F-3W**	**F-3WO***	**P-2WD**		**P-4WD**		**P-10WD**	
CLASS I SERVICES			**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Exams, Cleanings & Fluoride Treatments								
All X-Rays								
Sealants	100%	100%	100%	100%	100%	100%	100%	80%
Palliative Treatment (Emergency)								
Space Maintainers								
CLASS II SERVICES			**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Basic Restorative (Fillings, etc.)								
Repairs (Crowns, Inlays, Onlays, Bridges, Dentures)								
Oral Surgery (including Extractions)								
General Anesthesia	80%	80%	80%	50%	90%	80%	80%	80%
Endodontics								
Periodontics (Surgical and Nonsurgical)								
Posterior Resins (White Fillings)								
CLASS III SERVICES			**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Inlays, Onlays, Crowns	50%	50%	50%	25%	60%	50%	50%	50%
Prosthetics (Bridges, Dentures)								
ORTHODONTICS (dependent children to age 19)			**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Diagnostic, Active, Retention Treatment	Not Covered	50%	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Waiting Periods								
Class I services	None	None	None		None		None	
Class II services	None	None	None		None		None	
Class III services	None	None	None		None		None	
Orthodontic services	Not Covered	None	Not Covered		Not Covered		Not Covered	
DEDUCTIBLES & MAXIMUMS								
Calendar Year Deductible (Flex: waived for Orthodontics & Class I services) (Preferred: waived for Class I services)	$50/$150	$50/$150	$50/$150		$50/$150		$50/$150	
Calendar Year Maximum	$1,500	$1,500	$1,500		$1,500		$1,500	
Orthodontics (Lifetime Maximum) "case size qualifications apply"	Not Covered	$1,000	Not Covered		Not Covered		Not Covered	
Network								
Network Reimbursement	Elite Plus	Elite Plus	Elite Plus		Elite Plus		Elite Plus	
Out-of-Network Reimbursement	Based on Selection	Based on Selection		Based on Selection		Based on Selection		Based on Selection
Plan Features								
Smile for Health® Wellness - Core Provides periodontal care for people with certain chronic medical conditions. Eligible conditions: diabetes, heart disease, stroke, rheumatoid arthritis, lupus, organ transplant and head & neck radiation. Pregnancy is also a covered condition.	♦Covers 1 additional periodontal maintenance per year and all are covered at 100% ♦Scaling and root planing are covered at 100% ♦4 periodontal surgery procedures are covered at 100%							
Pregnancy Benefit	♦Covers 1 additional cleaning during pregnancy in addition to the benefits listed for Smile for Health® Wellness - Core							

* In order for a group with 10-24 enrolled contracts to qualify for dependent orthodontic coverage, the group must provide proof of prior fee-for-service orthodontic coverage.

United Concordia Dental PPO Plans

Dental Programs for Nevada Employer Groups with 2-50 Enrolled Contracts

Valid programs and rates for effective dates of July 1, 2026 through December 31, 2026.
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Valid in the following Zip Codes: 890xx - 898xx

Minimum Enrollment & Participation	**Groups 2-9**					**Groups 10-50**				
Minimum Enrolled	2	2	2	2		10	10*	10	10	10
Minimum Participation	**70%**	**70%**	**70%**	**70%**		**70%**	**70%**	**70%**	**70%**	**70%**
STANDARD PLAN OPTION	**F-3W**	**P-2WD**	**P-4WD**	**P-10WD**		**F-3W**	**F-3WO***	**P-2WD**	**P-4WD**	**P-10WD**
Advantage Out-of-Network										
Two-Tier Employee	$40.30	$33.60	$40.70	$39.50		$37.00	$37.00	$30.80	$37.40	$36.30
Family	$102.20	$85.00	$103.20	$100.20		$93.80	$105.80	$78.10	$94.70	$91.90
Four-Tier Employee	$40.30	$33.60	$40.70	$39.50		$37.00	$37.00	$30.80	$37.40	$36.30
Employee & 1 Adult	$79.80	$66.40	$80.60	$78.30		$73.30	$73.30	$60.90	$74.00	$71.80
Employee & Child(ren)	$72.20	$60.10	$72.90	$70.70		$66.20	$78.00	$55.10	$66.90	$64.90
Family	$121.00	$100.60	$122.20	$118.60		$111.00	$122.80	$92.30	$112.10	$108.80
90th Out-of-Network										
Two-Tier Employee	$43.40	$36.10	$43.90	$42.60		$39.90	$39.90	$33.20	$40.30	$39.10
Family	$110.00	$91.50	$111.10	$107.80		$101.00	$112.90	$84.00	$102.00	$99.00
Four-Tier Employee	$43.40	$36.10	$43.90	$42.60		$39.90	$39.90	$33.20	$40.30	$39.10
Employee & 1 Adult	$86.00	$71.50	$86.80	$84.30		$78.90	$78.90	$65.60	$79.70	$77.30
Employee & Child(ren)	$77.70	$64.60	$78.40	$76.10		$71.30	$83.10	$59.30	$72.00	$69.90
Family	$130.30	$108.30	$131.60	$127.70		$119.50	$131.30	$99.40	$120.70	$117.20

* In order for a group with 10-24 enrolled contracts to qualify for dependent orthodontic coverage, the group must provide proof of prior fee-for-service orthodontic coverage.

UNITED CONCORDIA® DENTAL

The following underwriting guidelines apply to the program on the attached document.

1. In network benefits are calculated using United Concordia's Maximum Allowable Charge (MAC). Out-of-network benefits are calculated based upon United Concordia's MAC or the 90th percentile of regional charge data depending on the plan selected.
2. Both minimum enrolled contract count and participation requirement must be achieved.
3. Spousal waive out count toward participation requirements but are not applicable to the minimum enrollment requirements.
4. Programs assume dependent children are eligible to age 26 and full-time students to age 26.
5. Class I, II, and III services count toward the maximum.
6. Standard United Concordia policies and procedures and exclusions and limitations apply (refer to Es & Ls included).
7. If the group is multi-state, at least 90% of those enrolled are located in the rate card region.
8. This chart is a representative listing of services covered under the proposed program.
9. The overall average number of members per contract is less than 5.
10. Dental plan is not offered in conjunction with another dental plan or another carrier.
11. The group has no claims experience available.
12. Client is not in one of the following industry categories: Dental Offices (SIC 8072); Dental Labs (SIC 8021); Employment agencies (SIC 7361), and any cannabis industries.
13. Rates on this card apply only to new business sold through United Concordia.
14. All proposed rates, guarantees and caps assume no change to the proposed benefit design. United Concordia reserves the right to re-evaluate proposed rates and benefit if any state or federally mandated benefits or fees are imposed. Rates are subject to regulatory approval.
15. Rates include 10% commission

United Concordia 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.

United Concordia will not accept business submitted by or pay commissions to producers who are not appointed. Any premium payment or group application submitted to United Concordia or its sales personnel by non-appointed producers must be accompanied by completed appointment paperwork or it will be returned to the non-appointed producer. A producer's quotation of rates to groups or submission of business to United Concordia constitutes acceptance of and agreement to comply with this rule. To obtain an appointment packet, visit the Producer section of www.unitedconcordia.com.

For use with rate card FFS for plans using MAC or 90th out of network

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.

The exclusions and limitations listed here are representation of the standard exclusions and limitations (form series 9809).

EXCLUSIONS – The following services, supplies or charges are excluded 18. For which in the absence of insurance the Member would incur no charge.

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, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile 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, whitening, personalization of crowns).

7. Elective procedures.

8. Procedures performed when poor prognosis is indicated.

9. Those procedures considered experimental and investigational based on current standards of dental treatment.

10. Those performed for the comfort and convenience of the Member or provider.

11. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).

12. For dental implant services unless specifically covered under the Schedule of Benefits or a Rider.

13. 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.

14. For treatment of fractures and dislocations of the jaw.

15. For treatment of malignancies or neoplasms.

16. Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation or reconstruction, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

17. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

18. Preventive restorations.

19. Periodontal splinting of teeth by any method.

20. For duplicate dentures, prosthetic devices or any other duplicative device.

21. For which in the absence of insurance the Member would incur no charge.

22. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.

23. 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.

24. For treatment and appliances for bruxism (night grinding of teeth).

25. 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.

26. Incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).

27. Procedures that are part of a service but are reported as separate services.

28. Procedures reported in a treatment sequence that does not align with accepted dental practice and evidence-based guidelines. For example, but not limitation, performing a restoration prior to addressing active periodontal disease. The determination of appropriate sequencing will be based on clinical documentation and established dental protocols and policy.

29. Procedures that are misreported or that represent a procedure other than the one reported

30. Specialized procedures and techniques (for example but not limitation, laser assisted new attachment procedure; laser assisted peri-implantitis procedure; laser decontamination).

31. Fees for broken appointments.

32. Those specifically listed on the Schedule of Benefits as “Not Covered" or “Plan Pays 0%”.

33. 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.

34. 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 calendar year(s).

2. Bitewing x-rays – one (1) set per 12 months under age nineteen and one (1) set per 18 months age nineteen (19) and older.

3. Oral Evaluations:

    - Comprehensive and periodic – two (2) of these services per 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 – three (3) per calendar year. One (1) additional for Members under the care of a medical professional during pregnancy.

5. Fluoride treatment – one (1) per 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 calendar 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) per 12 months in addition to routine prophylaxis.
   - Periodontal scaling and root planing – 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 calendar years of previous placement of any of the procedures in this category.
    - Buildups and post and cores – not within 5 calendar years of previous placement of any of the procedures in this category.
    - Replacement of natural tooth/teeth in an arch – not within 5 calendar 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 calendar 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 36 months. Recementation during the first 13 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. One orthodontic benefit is paid per eligible Member per lifetime. Orthodontic benefit based on treatment plan submitted by Your Dentist. Payment for orthodontic services, if covered, shall cease at the end of the month after termination by the Company.

17. Intraoral films
    - Periodical – 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.

19. Coverage for Orthodontics depends on plan design and availability and may be limited to Dependent children.

20. Diagnostic testing for cracked tooth: One (1) test per date of service with a dental exam or related service.

21. Collection, preparation and analysis of saliva sample: One (1) per 5 year(s).