

Dental
Underwriting Guidelines
Group Market

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Introduction

- λ This document reviews the underwriting guidelines for MWG Dental products. Dental Benefit Providers (DBP) underwriting for fully insured PPO & Indemnity products have developed these guidelines.

These guidelines have been developed to assist you in:

- ◆ Pre-qualifying your accounts
- ◆ Explaining significant details to your client or producers
- ◆ Procuring a quote for your accounts
- ◆ Renewing Accounts

If you have questions about these guidelines, please contact the MorganWhiteGroup

Robin Williams- Supervisor
Marketing
MorganWhiteGroup
PO Box 14067
Jackson, MS 39236
Ph: 800-800-1397 ext. 116
Fax: 601-956-1702
Email:
robinw@morganwhite.com

Description of Product Plans

Indemnity Dental Options

Indemnity Dental Products offer the insured maximum access to their dental care needs. The insured simply submits the claim forms to DBP for reimbursement whenever a dental procedure is rendered. DBP will administrate and adjudicate claims according to the certificate of coverage. The certificate of coverage explains the coinsurance purchased, levels of coverage, procedures covered and DBP's standard set of limitations and exclusions.

MorganWhiteGroup will offer 1 Indemnity plan (i1057).

PPO Dental Options

A **PPO** is a dental plan that allows members to choose care from an in- or out-of- network provider at the time of treatment. Members seeking care in-network benefit from increased coverage and reduced out-of-pocket costs based on contracted discount arrangements with participating dentists. The out-of-network

component works like an indemnity plan. The in-network delivery system is Discounted Fee-for-Service (DFFS) where a specified panel of providers has contracted to see dental plan beneficiaries at a reduced rate. Members have a financial incentive to select a “participating” dentist and receive a reduced level of coinsurance under the plan. Benefit plans usually feature coinsurance, deductibles and maximums.

MorganWhiteGroup will offer 2 Passive PPO Plan designs (p2603 and p2605) and 1 Incentive PPO Plan designs (p2604).

*A **Passive PPO** plan, provides members with the same deductible, coinsurance levels and maximums in- or out-of-network. However, there is financial incentive for members to seek care from an in-network dentist. While benefit levels are the same, the member’s out-of-pocket costs will be lower since in-network providers are contracted to accept reduced fees.*

*An **Incentive PPO** plan, provides members with richer benefits in-network than out-of-network. This type of plan provides incentive for members to seek care in-network while still allowing the flexibility to see any dentist of their choice.*

Features of the PPO Dental plan are:

- Network – At the time of treatment, members may see any dentist from a panel of participating providers to receive in-networks benefits. An up-front provider selection is not required.
- Access to Care – Referrals are NOT required. Members may access any provider in- or out-of-network at any time.
- Management Intensity – Discounted Fee-for-Service (DFFS) systems are generally not tightly managed. They feature relatively broad networks and few cost and quality controls. Any cost and quality management is largely a function of transactional intervention at the time of service.
- In-Network Provider Reimbursement – Services are usually subject to a discounted fee-for-service (DFFS) schedule that limits the amount provider charges. This is our schedule of maximum allowable charges (“MAC”).

New Business Underwriting Guidelines & Rating Process for Group with 2-200 Enrolled Employees

| Available Plans | Underwriting Requirements |
|-----------------|--|
| Indemnity PPO | <ul style="list-style-type: none"> ◆ Group sizes 2-200 enrolled employees ◆ For contributory plans, employer must contribute 50% or more to the employee rate ◆ For voluntary plans, employer is not required to contribute to the cost of the dental plan ◆ A virgin group is an employer that has not previously offered a dental plan to employees; a takeover group is an employer that has a current dental plan. ◆ Waiting periods are 12 months for Major & Orthodontia services for both voluntary & contributory plans (can be waived for premium increase) ◆ Waiting periods for Major & Ortho services on the takeover plans are waived for initial enrollees of groups who have had an acceptable level of dental coverage for the past 12 months. |

| Minimum Enrolled | | | | |
|--|--------------------------|------------------------------------|--|----------------------------|
| Voluntary and Contributory Groups | | | | |
| Virgin No Ortho | Virgin with Ortho | Voluntary Takeover No Ortho | Contributory Takeover No Ortho (100% participation) | Takeover with Ortho |
| 2 | 10 | 6 | 6 | 10 |

Quoting Software:

- Input the required data on the Group Info, Dental, Vision, and Agent sheets.
 - This rating engine will provide rates for groups with 2-200 enrolled employees (or eligible employees if the group is virgin to dental).
 - Rates will calculate only for the plans in which the MWG or DBP licensing allows (based on the zip code of the prospect).
 - The software will not be able to detect the group's industry automatically; therefore, either the SIC code or type of business, and industry adjustment must be entered so the necessary loads can be added to rated industries.
 - Industries which need rating loads are restaurants, automobile agencies (dealerships), motels/hotels, construction companies, health clubs, beauty salons/barber shops, small health care facilities (clinics, doctor offices), architects, engineers, law offices, computer programming, real estate companies, property management companies, or schools/school districts.
 - If a client is interested in making plan benefit changes, several options are available on the dental rater.
- If no broker commission adjustment is made, 8% broker commission will be included in the rates. To increase or decrease agent commission, enter the amount of change. For example, enter +2% to change the commission to 10%.
- DBP Underwriting will provide a custom plan number for implementation of plans created by using adjustment factors.

- If a client has more than 200 enrolled employees, a rate request will have to be sent to MorganWhiteGroup.

Other Rules:

- ◆ Eligibility – employees must work 20 hours or more per week to be eligible
- ◆ Rates are guaranteed for one year only
- ◆ No other dental carrier's plans may be offered with any of the MWG plans – full case takeover only, no slice business.
- ◆ Modifications to the Exclusions and Limitations will not be allowed (see Attachment A)
- ◆ Annual open enrollment is the group's anniversary date (unless changed). During open enrollment any eligible employee or their eligible dependents may enroll. New hires may enroll after completing the groups waiting period (effective the 1st of the next month).
- ◆ Late entrant – Anyone that does not enroll during the open enrollment period, can not enroll until the group's next annual open enrollment or a qualifying event occurs (Section 125).
- ◆ Section 125 is required on all voluntary MWG Dental plans. MorganWhite Group will provide Section 125 Document Package at "no charge".

Quote Process for Groups greater than 200:

- ◆ If a prospect has more than 200 enrolled employees, a request should be submitted to MorganWhiteGroup Marketing for rating at robinw@morganwhite.com, along with the following information:
 - ◆ Group Name
 - ◆ Effective Date
 - ◆ SIC Code
 - ◆ Census file (with age, gender, zip code, and enrollment tier of each employee) in Excel format
 - ◆ Situs Zip Code
 - ◆ Specific Broker commission percentage
 - ◆ Whether group is contributory or voluntary
 - ◆ Current & Proposed plan design(s)
 - ◆ Historic Claims vs. Premium reports (prefer 3 years, minimum 12 months of data)

MorganWhiteGroup will return a quote via email within 5 business days.

Case Acceptance

It is incumbent upon the Agent to ensure that cases are reviewed prior to installation and administration. The Agent should review the following items for accuracy:

- Case size (minimum threshold and actual membership)
- Rates quoted versus sold
- Employer Location
- Contributory vs. Voluntary

Cases, which deviate from what was quoted, must be re-underwritten prior to installation.

MorganWhiteGroup Contact Information

If you need to contact MorganWhiteGroup Marketing for rates or approval, email:

robinw@morganwhite.com

MorganWhiteGroup
PO Box 14067
Jackson, MS 39236
Ph: 800-800-1397 ext. 116
Fax: 601-956-1702

Attachment A: STANDARD EXCLUSIONS & LIMITATIONS

GENERAL LIMITATIONS

| | |
|---|--|
| Oral Examinations | Covered as a separate benefit only if no other service was done during the visit other than X-rays. Limited to once every 6 months. |
| Complete Series or Panorex Radiographs | Limited to one time per 36 months. |
| Bitewing Radiographs | Limited to 2 series of films per calendar year for enrollees under the age of 18; Limited to 1 series of films per calendar year for enrollees age 18 and over. |
| Extraoral Radiographs | Limited to 2 films per calendar year. |
| Dental Prophylaxis | Limited to once every 6 months. |
| Diagnostic Casts | Limited to one time per 24 months. |
| Fluoride Treatments | Limited to Covered Persons under the age of 19 years, and limited to once per six-month period. Treatment should be done in conjunction with dental prophylaxis. |
| Sealants | Limited to Covered Persons under the age of 15 years and once per first or second permanent molar every 5 years. |
| Space Maintainers | Limited to Covered Persons under the age of 16 years, once per lifetime. Benefit includes all adjustment within 6 months of installation. |
| Amalgam Restorations | Multiple restorations on one surface will be treated as a single filling. |
| Pin Retention | Limited to 2 pins per tooth; not covered in addition to Cast Restoration. |
| Gold Inlays and Onlays | Limited to one time per 5 calendar years. Covered only when silver fillings cannot restore the tooth. |
| Crowns | Limited to one time per tooth every 5 calendar years. Covered only when a filling cannot restore the tooth. |
| Post and Cores | Covered only for teeth that have had root canal therapy. |
| Sedative Fillings | Covered as a separate benefit only if no other service, other than X-rays and exam, were done during the visit. |
| Scaling and Root Planing | Limited to 1 time per quadrant per 24 months. |
| Periodontal Maintenance | Limited to 2 times within the first 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement. |
| Full Dentures | No additional allowances for over-dentures or customized dentures. |
| Partial Dentures | No additional allowances for precision or semi precision attachments. |
| Relining Dentures | Limited to relining done more than 6 months after the initial insertions. Limited to 1 time per calendar year. |
| Repairs to Full Dentures, Partial Dentures, Bridges | Limited to repairs or adjustments done within 12 months after the initial insertion. |

| | |
|----------------------|--|
| Palliative Treatment | Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit. |
| Occlusal Guards | Limited to one guard every 5 years. |

GENERAL EXCLUSIONS

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the Covered Person's eligibility with the Plan.
10. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12. Dental Services provided in a foreign country, unless required as an Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12-month period, the plan is responsible only for the procedures associated with the addition.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been eligible for 12 continuous months. If teeth were extracted while under previous carriers plan, the missing teeth clause is waived.
15. Full mouth radiograph series in excess of once every 36 months. Panoramic radiographs in excess of once every 36 months, except when taken for diagnosis of third molars, cysts, or neoplasm.
16. Hard tissue periodontal surgery and soft tissue periodontal surgery per surgical area in excess of once in any 36 month period. This includes gingivectomy, gingivoplasty, gingival curettage (with or without a flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.
17. Osseous grafts, with or without resorbable or non-resorbable GTR membrane placement in excess of once every 36 months per quadrant or surgical site.
18. Root planing and scaling (ADA Code 4341) in excess of once every 24 months per quadrant.
19. Full mouth debridement (ADA Code 4355) in excess of once every 36 months.
20. Replacement of complete or partial dentures, fixed bridgework, or crowns previously submitted for payment under the Plan within sixty (60) months of initial or supplemental placement. This

- includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
21. Replacement of complete or partial dentures, crowns, or fixed bridgework if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
 22. Denture relines for complete or partial conventional dentures for the 6-month period following the insertion of prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures for the first six 6 months. After the six-month waiting period, relines are covered not more than once every 12 months.
 23. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
 24. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
 25. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
 26. Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
 27. Placement of fixed bridgework solely for the purpose of achieving periodontal stability.
 28. Billing for incision and drainage (ADA Code 7510) if the involved abscessed tooth is removed on the same date of service.
 29. Treatment of malignant or benign neoplasm, cysts, or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision.
 30. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
 31. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
 32. Acupuncture; acupressure and other forms of alternative treatment.
 33. General Anesthesia, except if required for patients less than 6 years of age or patients with behavioral problems or physical disabilities.
 34. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
 35. Occlusal guards except if prescribed to control of habitual grinding, including those specifically used as safety items or to affect performance primarily in sports-related activities.
 36. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.