Attachment N9

UnitedHealthcare dental plan

Voluntary Options PPO/covered dental services Custom P3271

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$25 per individual	$25 per individual	N/A	N/A
Family Annual Deductible	$25 per individual	$25 per individual	N/A	N/A
Maximum *(the sum of all Network and Non-Network benefits will not exceed annual maximum)*	$1000 per person per Calendar	$1000 per person per Calendar	N/A	N/A

New enrollee's waiting period:	No
Annual deductible applies to preventive and diagnostic services	No
Annual deductible applies to orthodontic services	N/A
Orthodontic eligibility requirement	N/A

COVERED SERVICES	NETWORK PLAN PAYS*	NON-NETWORK PLAN PAYS**	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC			
Oral Evaluations (Diagnostic)	100%	100%	Covered as a separate benefit only if no other service was done during the visit other than X-rays. Limited to 2 times per calendar year.
X Rays (Diagnostic)	100%	100%	Bite-wing: Limited to 1 series of film per consecutive 36 months. Complete/Panorex: Limited to one time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	100%	
Prophylaxis (Preventive)	100%	100%	Limited to 2 times per calendar year.
Fluoride Treatment (Preventive)	100%	100%	Limited to Covered Persons under the age of 19 years, and limited to 2 times per calendar year. Treatment should be done in conjunction with dental prophylaxis.
Sealants	100%	100%	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	Limited to Covered Persons under the age of 14 years, once per consecutive 60 months. Benefit includes all adjustment within 6 months of installation.
Periodontic Maintenance	100%	100%	Perio Maintenance: Limited to 2 times per calendar year, or 2 prophy's or combination of one prophy and one perio per calendar year, not to exceed 2 per calendar year.
BASIC SERVICES			
Restorations (Amalgams and Resin Based Only)	50%	50%	Multiple restorations on one surface will be treated as a single filling. Limited to once per tooth every 24 months. Composite: for anterior teeth only.
General Services (incl. Emergency Treatment)	50%	50%	Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: when clinically necessary.
Simple Extractions	50%	50%	
Oral Surgery (includes surgical extractions)	50%	50%	
Periodontics	50%	50%	Perio Surgery: Limited to once every consecutive 36 months per surgical area. Root Planning: Limited to one time per quadrant per consecutive 24 months.
Endodontics	50%	50%	
MAJOR SERVICES			
Inlays/Onlays/Crowns	50%	50%	Limited to one time per tooth per consecutive 60 months. Covered only when silver fillings cannot restore the tooth.
Dentures and other Removable Prosthetics	50%	50%	Once every 60 months. No additional allowances for over-dentures or customized dentures. Relining and rebasing dentures is limited to 1 time every 36 months.
Fixed Prosthetics	50%	50%	Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.(alternate benefits for a partial denture may be applied)
ORTHODONTIC SERVICES			
Orthodontia	0%	0%	N/A

This plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future periods.

*The network percentage of benefits is based on the discounted fee negotiated with the provider.

**The non-network percentage of benefits is based on the usual and customary rates prevailing in the geographic areas in which the expenses are incurred.

Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment upon which the plan benefit is based, your actual out-of-pocket expense will be: the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the fee for the service actually rendered and the fee for the service upon which the plan benefit is based..

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above ta ble provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; or United HealthCare Services, Inc.

UnitedHealthcare/Dental Exclusions and Limitation

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 2 times per calendar year.**

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to one time per consecutive 36 months.

BITEWING RADIOGRAPHS Limited to **1 series of films per** consecutive 36 months**.**

EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

DENTAL PROPHYLAXIS Limited to 2 times per calendar year

DIAGNOSTIC CASTS Limited to one time per consecutive 24 months.

FLUORIDE TREATMENTS Limited to Covered Persons under the age of 19 years, and limited to 2 times per calendar year. Treatment should be done in conjunction with dental prophylaxis.

SEALANTS Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.

SPACE MAINTAINERS Limited to Covered Persons under the age of **14** years, once per 60 consecutive months. Benefit includes all adjustment within 6 months of installation.

AMALGAM RESTORATIONS Multiple restorations on one surface will be treated as a single filling. Limited to once per tooth every 24 months.

PIN RETENTION Limited to 2 pins per tooth; not covered in addition to Cast Restoration.

GOLD INLAYS AND ONLAYS Limited to one time per tooth per consecutive 60 months. Covered only when silver fillings cannot restore the tooth.

CROWNS Limited to one time per tooth per consecutive 60 months. 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 consecutive 24 months.

PERIODONTAL MAINTENANCE Limited to 2 times per calendar year following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.

FULL DENTURES Once every 60 months. 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 every 36 months.**

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments done more than 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 per consecutive 36 months. Only covered for habitual grinding.

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.
15. Replacement of complete dentures, fixed and removable partial dentures or crowns 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.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. 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.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Placement of dental implants, implant-supported abutments and prostheses (D6053-D6199). This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
20. Placement of fixed partial dentures (D6210- D6793, D6920) solely for the purpose of achieving periodontal stability.
21. Billing for incision and drainage (ADA Code D7510, D7520) if the involved abscessed tooth is removed on the same date of service.
22. Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision. (D7413-D7415, D7440-D7441, D7485-D7490).
23. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue (D7610-D7780).
24. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral (D7810-D7899). Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery (D7920-D7949), jaw alignment or treatment for the temporomandibular joint.
25. Acupunture; acupressure and other forms of alternative treatment.
26. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
27. Occlusal guard used as safety items or to affect performance primarily in sports-related activities (D9941).
28. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
29. Services of a participating provider than can be effectively treated by a less costly, clinically acceptable alternative procedure in accordance with the "Standards of Care" established by DBP with its participating providers. These services, if appropriate, will be covered under the less costly clinically acceptable alternative procedure.