## Unified Healthcare

**Voluntary Options PPO/covered dental services**

**Custom P4935**

### Dental Plan Summary

**Plan Year Deductible**
- Individual: $0
- Family: $0
- Non-Network: $500 per person per Plan Year

**New enrollee's waiting period:**
- Plan year deductible applies to preventive and diagnostic services: No (In Network) No (Out Network)

### COVERAGE SERVICES

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIAGNOSTIC SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic Oral Evaluation</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td>Radiographs</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td>Lab and Other Diagnostic Tests</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>PREVENTIVE SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prophylaxis (Cleanings)</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td>Fluoride Treatment (Preventive)</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td>Sealants</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td>Space Maintainers</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>BASIC SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restorations (Amalgam or Anterior Composite)*</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td>Emergency Treatment / General Services</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>MAJOR SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple Extractions</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Oral Surgery (includes surgical extractions)</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Periodontics</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Endodontics</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Inlays/Onlays/Crowns*</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Dentures and other Removable Prosthetics</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Fixed Partial Dentures (Bridges)*</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Benefit Guidelines

- **NETWORK PLAN**
  - Periodic Oral Evaluation: 100%
  - Radiographs: 100%
  - Lab and Other Diagnostic Tests: 100%
  - Prophylaxis (Cleanings): 100%
  - Fluoride Treatment (Preventive): 100%
  - Sealants: 100%
  - Space Maintainers: 100%
  - Restorations (Amalgam or Anterior Composite)*: 100%
  - Emergency Treatment / General Services: 0%
  - Simple Extractions: 0%
  - Oral Surgery (includes surgical extractions): 0%
  - Periodontics: 0%
  - Endodontics: 0%
  - Inlays/Onlays/Crowns*: 0%
  - Dentures and other Removable Prosthetics: 0%
  - Fixed Partial Dentures (Bridges)*: 0%

- **NON-NETWORK PLAN**
  - Periodic Oral Evaluation: 60%
  - Radiographs: 60%
  - Lab and Other Diagnostic Tests: 60%
  - Prophylaxis (Cleanings): 60%
  - Fluoride Treatment (Preventive): 60%
  - Sealants: 60%
  - Space Maintainers: 60%
  - Restorations (Amalgam or Anterior Composite)*: 60%
  - Emergency Treatment / General Services: 0%
  - Simple Extractions: 0%
  - Oral Surgery (includes surgical extractions): 0%
  - Periodontics: 0%
  - Endodontics: 0%
  - Inlays/Onlays/Crowns*: 0%
  - Dentures and other Removable Prosthetics: 0%
  - Fixed Partial Dentures (Bridges)*: 0%

### Notes

- 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 agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

- The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table 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.

- The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

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

***The benefit percentage applies to the schedule of maximum allowable charges. Maximum allowable charges are limitations on billed charges in the geographic area in which the expenses are incurred.
General Limitations

PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

COMPLETE SERIES OR PANOREX RADIOPHGRAPHS Limited to one time per consecutive 36 months. Exception to this limit will be made for Panorex Radiograph if taken for diagnosis of molars, cysts or neoplasms.

BITEWING RADIOPHGRAPHS Limited to 1 series of films per Plan Year.

EXTRORAL RADIOPHGRAPHS Limited to 2 films per Plan Year.

DENTAL PROPHY/LAXIS Limited to 2 times per consecutive 12 months.

FLUORIDE TREATMENTS Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

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

SPACE MAINTENANCE Limited to Covered Persons under the age of 16 years. Limited to 1 per consecutive 60 months.

Benefit includes all adjustments within 6 months of installation.

RESTORATIONS Multiple restorations on 1 surface will be treated as a single filling.

PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.

INLAYS AND ONLAYS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

CROWNS Limited to 1 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.

SODATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam were performed on the same tooth during the visit.

SCALE AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

REPAIRS AND REBASED DENTURES Limited to relining/rebuilding performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Limited to 1 replacement per consecutive 36 months. Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

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 governmental 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 becoming enrolled under the policy.
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. Foreign services are not covered 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 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.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been covered under the plan 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 prosthetic 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, implants-supported abutments and prostheses. (Not applicable for Plans with implants)
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
22. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
23. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint. (Not Applicable for Plans with TMJ).
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
26. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
27. Occlusal guard used as safety items or to affect performance primarily in sports-related activities.
28. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
29. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.