

# United Concordia Summary of Benefits – High Option

This summary provides an overview of your dental benefits effective January 1 2010 and is not a Certificate of Coverage. The Certificate of Coverage will provide additional detailed information and is the finalized documentation.

## Individual maximum benefit:

*\$1,500 per calendar year per member for Preventive, Basic and Major Services.*

## Individual deductible:

*\$50 per calendar year per member for Basic and Major Services.*

## Maximum family deductible:

*Calendar year maximum of \$150.*

## Orthodontic lifetime maximum benefit:

*\$1,000 per each covered dependent child to age 19.*

## Preventive Services:

*Benefits are paid at 100%.*

1. Routine teeth cleaning (prophylaxis)
2. Topical fluoride treatment
3. Sealants
4. X-rays
5. Oral examinations

## Basic Services:

*Benefits are paid at 80% after the deductible.*

1. Fillings (amalgam and composite restorations)
2. Non-surgical extractions
3. Non-surgical residual root removal
4. Non-cast prefabricated crowns
5. Emergency exam and palliative care for pain relief
6. Space maintainers
7. Harmful habits and thumb-sucking appliances
8. Partial and denture repairs and adjustments
9. Oral surgery
10. Periodontics (gum disease)
11. Endodontics (root canals)

## Major Services:

*Benefits are paid at 50% after the deductible.*

1. Crowns
2. Inlays and onlays
3. Removable or fixed bridgework
4. Partial or complete dentures
5. Denture relines or rebases

## Orthodontic Services:

*Benefits are paid at 50% and will be prorated if services are currently in progress.*

## Your plan benefits

### Preventive services

1. Oral evaluations (periodic, limited, comprehensive and problem focused) - two per *calendar year*.

2. Periodontal evaluations - two per *calendar year*.
3. Cleaning (prophylaxis), including all scaling and polishing procedures – two per *calendar year*.
4. Intra-oral complete series X-rays (at least 14 films, including bitewings), or panoramic film X-rays – once every five years. If the total cost of periapical and bitewing x-rays exceeds the cost of a complete series of x-rays, the plan will consider these as a complete series.
5. Bitewing X-rays –one set per *calendar year*.
6. Other X-rays – only to diagnose specific treatment.
7. Topical fluoride treatment – provided to *dependents* age 14 and younger. *Service* is payable once per *calendar year*.
8. Sealants – application provided to *dependents* age 14 and younger to the occlusal surface of
9. permanent molars that are free of decay and restorations. *Service* is payable once per tooth per lifetime.
10. We will not cover preventive control programs including, but not limited to, oral hygiene instructions,
11. plaque control, take-home items, prescriptions and dietary planning.

### Basic services

1. Amalgam restorations (fillings) – limit to one per tooth in a two year period. Multiple restorations on one surface are considered one restoration.
2. Composite restorations (fillings) limited to one per tooth in a two year period. Multiple restorations on one surface are considered one restoration.
3. Pin retention in addition to an amalgam or composite restoration – this is not covered as a separate *covered expense* when done in conjunction with a core build-up.
4. Recementing of inlays, onlays, crowns and bridges.
5. Non-cast pre-fabricated crowns – *service* on primary teeth that cannot be adequately restored with amalgam or composite restorations.
6. Space maintainers for retaining space when a primary tooth is prematurely lost. *Services* are payable only for *dependents* age 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.
7. Fixed and removable appliances to inhibit thumb sucking and other harmful habits. *Services* are payable only for *dependents* age 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.
8. *Emergency* care – treatment for the initial *palliative* care of pain and/or injury. *Services* include *palliative* procedures for treatment to the teeth and supporting structures. We will consider the *service* as a separate *benefit* only if no other *service*, except X-rays, is provided during the same visit.
9. Full or partial denture repair.
10. Consultation – diagnostic service provided by a dentist or physician other than practitioner providing the treatment. Coverage is limited to one consultation per provider.

### Oral surgery services

1. Extractions.
2. Bone Smoothing;
3. Trim or Remove over growth or non vital tissue or bone; or
4. Removal of tooth or root from sinus and closing opening between mouth and sinus.
5. General anesthesia when *medically necessary* and administered by a *dentist* in conjunction with a covered oral surgical procedure.
6. We will not cover any *services* for orthognathic surgery.
7. We will not cover any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
8. We will not cover *services* generally considered to be medical *services*.
9. Separate fees for pre and post operative services are not a *covered expense*.

### Periodontic services

1. Periodontal scaling and root planing, available at a maximum of once per quadrant in a three-year period.
2. Periodontal surgery, available at a maximum of once per quadrant in a three-year period. If more than one surgical *service* is performed on the same day, we will consider only the most inclusive *service* performed as a *covered service*.
3. Occlusal adjustments when performed in conjunction with periodontal surgery – available at a
4. maximum of once per quadrant in a three-year period.

5. Periodontal maintenance (following periodontal therapy) – procedure available twice per *calendar year*.
6. Separate fees for pre and post operative care and re-evaluation within three months are not covered.

#### Endodontic services

1. Root canal therapy, including root canal treatments and root canal fillings – procedure available to permanent teeth only, once per tooth in a two-year period. Any X-ray, test, laboratory, exam or follow-up care is considered integral to root canal therapy.
2. Apicoectomy - procedure available for permanent teeth only.
3. Vital pulpotomy – procedure available for deciduous (baby) teeth only.

#### Major/Prosthetic services

1. Repairs of bridges; full or partial dentures, and crowns.
2. Denture adjustments – procedure available only for adjustments done by a *dentist* other than the one providing the denture, or adjustments performed more than six months after initial installation.
3. Initial placement of laboratory-fabricated restorations when the tooth, as a result of extensive decay or traumatic injury, cannot be restored with a direct placement filling material. *Covered services* include inlays, onlays, crowns, veneers, core build-ups and posts. These *services* are covered only on permanent teeth.
4. Initial placement of bridges, and full and partial dentures only if the functioning tooth (excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis) was extracted while *you* are covered under this plan. *Covered expense* includes fixed bridges, removable partial dentures and full dentures. *Services* include all adjustments and relines within six months after installation and are payable only for treatment on permanent teeth. *We will not cover* replacement of congenitally missing teeth.
5. Replacement of bridges, partials, dentures, inlays, onlays, crowns or other laboratory-fabricated restorations. The existing major restoration or prosthesis can be replaced only if:
  - a. It has been at least five years since the prior insertion and is not, and can not be made,
6. serviceable;
  - a. It is damaged beyond repair as a result of an *accidental injury* (non-chewing injury) while in the
7. oral cavity; or
  - a. Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an
8. opposing tooth or prosthesis, necessitates the replacement of the prosthesis.
  - a. These *services* are covered only on permanent teeth.
9. Denture relines or rebases – once in a three-year period.
10. *We will not cover expense incurred* for pin retention when done in conjunction with core build-up.
11. *We will not cover* the replacement of any lost, stolen, damaged, misplaced or duplicate major
12. restoration, prosthesis or appliance.

#### Integral service

The following *services* are considered integral to the dental *service*. A separate fee for these *services* is not considered a *covered expense*.

1. Local anesthetics;
2. Bases;
3. Pulp caps;
4. Temporary dental *services*;
5. Study models/diagnostic casts;
6. Treatment plans;
7. Occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments;
8. Nitrous oxide;
9. Irrigation;
10. Tissue preparation associated with impression or placement of a restoration.

*We do not cover* caries susceptibility testing, lab tests, anaerobic cultures, sensitivity testing or charges for oral pathology procedures. *We do not cover services* that generally are considered to be medical *services* except those outlined in this section.

General anesthesia is not a *covered expense* unless it is a *medical necessity* and administered by a *dentist* in conjunction with covered oral surgical procedures outlined in this section. Patient management or apprehension is not considered a *medical necessity*.

## Summary of Limitations & Exclusions (all services)

In addition to the limitations and exclusions listed in **Your plan benefits** section, this policy does not provide *benefits* for the following:

1. Any *expenses incurred* while *you* qualify for any worker's compensation or occupational disease act or law, whether or not *you* applied for coverage.
2. *Services*:
  - a. That are free or that *you* would not be required to pay for if *you* did not have this insurance,
3. unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
  - a. Furnished by, or payable under, any plan or law through any government or any political
4. subdivision (this does not include Medicare or Medicaid); or
  - a. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury*.
5. Any loss caused or contributed by:
  - a. War or any act of war, whether declared or not;
  - b. Any act of international armed conflict; or
  - c. Any conflict involving armed forces of any international authority.
6. Any expense arising from the completion of forms.
7. *Your* failure to keep an appointment with the *dentist*.
8. Any *service* we consider *cosmetic dentistry* unless it is necessary as a result of an *accidental injury* sustained while *you* are covered under this policy. We consider the following *cosmetic dentistry* procedures:
  - a. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
  - b. Any *service* to correct congenital malformation;
  - c. Any *service* performed primarily to improve appearance; or
  - d. Characterizations and personalization of prosthetic devices.
9. Charges for:
  - a. Any type of implant and all related services, including crowns or the prosthetic device attached to it.
  - b. Precision or semi-precision attachments.
  - c. Overdentures and any endodontic treatment associated with overdentures.
  - d. Other customized attachments.
10. Any *service* related to:
  - a. Altering vertical dimension of teeth;
  - b. Restoration or maintenance of occlusion;
  - c. Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
  - d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
  - e. Bite registration or bite analysis.
11. Infection control, including but not limited to sterilization techniques.
12. Fees for treatment performed by someone other than a *dentist* except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards.
13. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthetist.
14. Prescription drugs or pre-medications, whether dispensed or prescribed.
15. Any *service* not specifically listed in **Your plan benefits**.
16. Any *service* that *we* determine:
  - a. Is not a *dentally necessity*;
  - b. Does not offer a favorable prognosis;
  - c. Does not have uniform professional endorsement; or
  - d. Is deemed to be experimental or investigational in nature.
17. Orthodontic *services* unless specified in *your* **Summary of your benefits**.
18. Any *expense incurred* before *your* effective date or after the date *your* coverage under this policy terminates (unless the *service* is eligible under **Extension of benefits**).
19. *Services* provided by someone who ordinarily lives in *your* home or who is a *family member*.
20. Charges exceeding the *reimbursement limit* for the *service*.
21. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.

22. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental *services*, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service*.
23. Repair and replacement of orthodontic appliances.
24. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.

### **Alternate services**

If two or more *services* are acceptable to correct a dental condition, we will base the *benefits* payable on the *covered expenses* for the least expensive *covered service* that produces a professionally satisfactory result, as determined by us. We will pay up to the *reimbursement limit* for the least costly *covered service* and subject to any *deductible*, *coinsurance* and *maximum benefit*. You will be responsible for paying the excess amount.

If you or your dentist decide on a more costly treatment than we determine to be satisfactory for treatment of the condition, payment will be limited to the *reimbursement limit* and will be subject to any *deductible* and *coinsurance* for the least costly treatment. You will be responsible for the remaining *expense incurred*.

### **Pretreatment plan**

We suggest that if dental treatment is expected to exceed \$300, you or your dentist submit a dental *treatment plan* for us to review before your treatment. The dental *treatment plan* should consist of:

1. A list of *services* to be performed using the American Dental Association nomenclature and codes;
2. Your dentist's written description of the proposed treatment;
3. Supporting pretreatment X-rays showing your dental needs;
4. Itemized cost of the proposed treatment; and
5. Any other appropriate diagnostic materials that we may request.

An estimate for *services* is not a guarantee of what we will pay. It tells you and your dentist in advance about the *benefits* payable for the *covered expenses* in the *treatment plan*. We will notify you and your dentist of the *benefits* payable based on the submitted *treatment plan*.

An estimate for *services* is not necessary for *emergency care*.