

2009 FIRE FIGHTERS UHC DENTAL OPTIONS PPO COVERED DENTAL SERVICES

DENTAL PLAN CODE

	Non-Orthodontics		Orthodontics	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Annual Deductible	\$25	\$50	\$0	\$0
Family Annual Deductible	\$75	\$150	\$0	\$0
Maximum (combined for both In-Network and Out-of-Network services)	\$1,800 per person per calendar year	\$1800 per person per calendar year	\$2,250 per person per lifetime	\$2,250 per person per lifetime

Annual deductible applies to preventive and diagnostic services	No
Annual deductible applies to orthodontic services	No
For new enrollees, a 12-month waiting period applies to major services & orthodontics	No
Orthodontic eligibility requirement	Child/ Adult

Covered Services	In-Network Plan Pays*	Out-of-Network Plan Pays**	Benefit Guidelines
PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES			
Periodic Oral Examinations	100%	80%	Two per Calendar Year
Bitewing X-rays	100%	80%	One series of films per year.
Complete Series or Panorex X-rays	100%	80%	One time per 36 months.
Dental Prophylaxis (Cleanings)	100%	80%	Two per Calendar Year
Fluoride Treatments	100%	80%	For covered persons under the age of 16 years, 2 per Calendar Year
Sealants	100%	80%	For covered persons under the age of 16 years, once per first or second permanent molar every 5 years.
BASIC DENTAL SERVICES (Minor Restorative, Endodontics, Periodontics and Oral Surgery)			
Amalgam Restorations (Fillings)	80%	80%	One restoration allowed per surface every 3 years.
Composite Resin Restorations (Fillings)	80%	80%	One restoration allowed per surface every 3 years.
Space Maintainers	80%	80%	For covered persons under the age of 16 years, once per lifetime.
Root Canal Treatment	80%	80%	Once per site per lifetime.
Root Planing	80%	80%	Once every 24 months per quadrant.
Periodontal Surgery	80%	80%	Once every 36 months per site.
Simple Extraction	80%	80%	
Surgical Extraction including Impacted Wisdom Teeth	80%	80%	
General Anesthesia	80%	80%	When clinically necessary.
Palliative Treatment (Relief of Pain)	80%	80%	Covered as a separate benefit only if no other services except exam and X-rays were performed during the visit.
MAJOR DENTAL SERVICES			
Crowns	50%	50%	Once every 5 years.
Fixed Bridges	50%	50%	Once every 5 years (alternate benefits for a

			partial denture may be applied).
Full Dentures	50%	50%	Once every 5 years; no allowance for overdentures or customized dentures.
Inlays and Onlays	50%	50%	Once every 5 years.
Partial Dentures	50%	50%	Once every 5 years; no allowance for precision or semi precision attachments.
Relining Dentures	50%	50%	Once every year after the 6 month period following initial insertion.
Repairs to Full Dentures, Partial Dentures, Bridges	50%	50%	For repairs or adjustments done after 12 months following the initial insertion.
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite including Phase I and Phase II	50%	50%	Preauthorization required.

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

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

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.