Dental **BENEFITS**

Fee-For-Service

Benefits Effective January 1, 2010

SecureHorizons® MedicareComplete® Retiree Plan (FFS)

SecureHorizons®
by UnitedHealthcare

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SECTION 1: Introducing the Fee-For-Service Dental Plan

The information in this document describes the Fee-For-Service dental benefits that are Covered Health Services when you follow our Coverage Rules in the Evidence of Coverage. These services are in addition to Medicare-covered benefits outlined in your Retiree Benefits Summary Booklet and Insert. The provisions of this document are incorporated into and made a part of your Evidence of Coverage. The Covered Health Services described in this document are not covered when you are in the service area of an Affiliated Organization; as defined in the Passport Program Section of your Evidence of Coverage, if applicable. Copayments or Coinsurance for these Covered Health Services do not apply toward the Annual Out-of-Pocket Maximum described in your Retiree Benefits Summary Booklet and Insert.

SECTION 2: Glossary of Dental Terms

1. **Covered Dental Services** — those dental benefits, treatments and services listed in this Dental Benefits booklet and provided by a licensed Dentist, except as limited or excluded either by this document or by the terms of the Evidence of Coverage.
2. **Dentist** — a person (D.D.S. or D.M.D.) who is licensed to practice dentistry in the state where services are rendered and is acting within the scope of that license. A Dentist may also be a licensed physician performing dental services within the scope of that license.
3. **Exclusion** — any services or items not included under the Dental Plan.
4. **Limitation** — any restriction on Covered Dental Services (other than an Exclusion) under the Dental Plan.
5. **Prophylaxis (Teeth Cleaning)** — the routine cleaning of the teeth including polishing and required supragingival (above the gum) and coronal scaling.
6. **Usual, Customary and Reasonable (UCR)** — the fee dental providers most frequently charge for services rendered.

SECTION 3: Covered Dental Services

With this plan, you are covered for diagnostic, preventive, minor and major dental services, as listed in the chart below.

Individual Annual Deductible (Combined for both In-Network and Out-of-Network services)*	$50 per calendar year
Calendar Year Maximum (Combined for both In-Network and Out-of-Network services)	$1,000 per calendar year

Covered Services	Dental Benefit Pays	Benefit Guidelines
PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES		
Periodic Oral Examinations	100%	Up to once per six-month period.

Covered Services	Dental Benefit Pays	Benefit Guidelines
Bitewing X-rays	100%	One series of films every 12 months.
Complete Series or Panorex X-rays	100%	One time per 36 months.
Prophylaxis (Cleanings)	100%	Up to once per six-month period.
Fluoride Treatments	100%	For covered persons under the age of 16 years, up to one per six-month period.
BASIC DENTAL SERVICES (Minor Restorative)		
Amalgam Restorations (Fillings)	80%	One restoration allowed per surface every three years.
Composite Resin Restorations (Fillings)	80%	One restoration allowed per surface every three years.
MAJOR DENTAL SERVICES (Endodontics, Periodontics and Oral Surgery)		
Root Canal Treatment	50%	Once per site per lifetime.
Root Planing	50%	Once every 24 months per quadrant.
Periodontal Surgery	50%	Once every 36 months per site.
Simple Extraction	50%	
Surgical Extraction including Impacted Wisdom Teeth	50%	
General Anesthesia	50%	When clinically necessary.
Palliative Treatment (Relief of Pain)	50%	Covered as a separate benefit only if no other services except exam and X-rays were performed during the visit.
Crowns	50%	Once every five years.
Fixed Bridges	50%	Once every five years (alternate benefits for a partial denture may be applied).
Full Dentures	50%	Once every five years; no allowance for overdentures or customized dentures.
Inlays and Onlays	50%	Once every five years.

Covered Services	Dental Benefit Pays	Benefit Guidelines
Partial Dentures	50%	Once every five years; no allowance for precision or semi precision attachments.
Recement Bridges, Crowns, Inlays	50%	Once every six months per restoration.
Relining Dentures	50%	Once every year after the six-month period following initial insertion.
Repairs to Full Dentures, Partial Dentures, Bridges	50%	For repairs or adjustments done after 12 months following the initial insertion.

* Annual Deductible does not apply to preventive and diagnostic services

No waiting periods apply to Covered Dental Services

Reimbursement Schedule: Usual, Customary and Reasonable (UCR)

SECTION 4: How to Choose a Dentist

Once you become a member you will want to learn how to take advantage of your Dental Benefits. Here's how to get started:

Simply select a Dentist of your choice. After you have selected a Dentist, just call and make an appointment. Be sure to tell the dental office that you are a Member of SecureHorizons® MedicareComplete® Retiree Plan (FFS).

Only Covered Dental Services will be covered under this Dental Benefits booklet. You must pay all fees for non-covered services to the Dentist at the time of service.

SECTION 5: Claims

When you have Covered Dental Services performed, it is customary for the Dentist to submit a Claim on your behalf. If this is not standard procedure for your Dentist, you may request reimbursement from us. To receive reimbursement for your dental services, please take the following steps:

1. Obtain a copy of your bill marked "paid" from the Dentist
2. Make sure the bill includes the following:
   a. The Dentist's name, address and phone number
   b. The itemized services with Current Dental Terminology (CDT) codes and charges
   c. Your name, address and phone number
3. Mail the bill(s) to:

For Arizona:
SecureHorizons® MedicareComplete® Retiree Plan
Claims Department
P.O. Box 52078
Phoenix, AZ 85072

For California:
SecureHorizons® MedicareComplete® Retiree Plan
Claims Department
P.O. Box 30968
Salt Lake City, UT 84130-0968

For Colorado:
SecureHorizons® MedicareComplete® Retiree Plan
Claims Department
P.O. Box 52064
Phoenix, AZ 85072-2064

For Nevada:
P5 Health Solution
700 E. Warm Springs Rd. Ste. 302
Las Vegas, NV 89119

For Oklahoma:
SecureHorizons® MedicareComplete® Retiree Plan
Claims Department
P.O. Box 30967
Salt Lake City, UT 84130-0967

For Oregon:
SecureHorizons® MedicareComplete® Retiree Plan
Claims Department
P.O. Box 30974
Salt Lake City, UT 84130-0974

For Texas:
SecureHorizons® MedicareComplete® Retiree Plan
Claims Department
P.O. Box 30975
Salt Lake City, UT 84130-0975

For Washington:
SecureHorizons® MedicareComplete® Retiree Plan
Claims Department
P.O. Box 30976
Salt Lake City, UT 84130-0976

4. We will process your reimbursement based on your benefits. Upon completion of the reimbursement process, an Explanation of Benefits (EOB) will be sent to your mailing address.

A Claim from either the Dentist or you should be furnished to us within ninety (90) days after the date of service, or as soon thereafter as reasonably possible.

Limitation of Liability

We will not reduce or deny a Claim for failure to furnish such proof within the time required, provided a Claim is furnished as soon as reasonably possible. Except in the absence of legal capacity, we will not accept a Claim more than one (1) year from the date of service.

SECTION 6: General Provisions for Dental Services

Recovery of Payments. We reserve the right to deduct from any benefits properly payable under the Dental Benefits booklet the amount of any payment that has been made:

1. in error;
2. due to a misstatement contained in a Claim;
3. due to a misstatement made to obtain coverage;
4. with respect to an ineligible person; this deduction may be made against any Claim for benefits under the Dental Benefits booklet by you if such payment is made with respect to you. No request for a refund of all or a portion of a payment of a Claim to you or to a Dentist will be made after 24 months from the Claim payment date. The only exceptions to this are when the payment was made because of fraud committed by you or the Dentist, or if you or the Dentist has otherwise agreed to make a refund for overpayment of a Claim.

SECTION 7: Limitations and Exclusions

The following dental procedures and services described below are limited and excluded Dental Services under the Dental Benefits booklet:

1. All dental procedures other than the Covered Dental Services under this Dental Benefits booklet.
2. The provision of dental services in hospitals, extended care facilities or your home where conditions were caused by medical care or hospitalization.
3. Services which are provided to you by a state government or agency or are provided without cost to you by a municipality, county or other subdivision.
4. Dental expense incurred in connection with any dental procedure started after termination of eligibility for benefits.
5. Work-in-progress such as the completion of dental services started before your effective date with the Plan.
6. Drugs prescribed by a Dentist or drugs used for dental treatment, except in accordance with Medicare guidelines.
7. Any dental procedure unable to be performed in the dental office because of your general health and physical limitations.
8. The provision of dental services which would not be consistent with your dental needs and/or generally accepted professional standards of dental therapeutics.
9. Medical services for treatment of fractures, dislocations, tumors, non-dentigerous cysts, and neoplasms, and other medically necessary surgeries of the jaw or related joints including Temporomandibular Joint Disorder (TMJ). Requests for such services should be discussed with your Primary Care Physician.
10. Liability insurance cases: dental care that is covered under automobile, medical, no-fault or similar type insurance.
11. A charge for a service not furnished by a Dentist. This does not apply if the service is performed by a licensed Dental Hygienist under the direction of a Dentist.
12. Services and supplies not specifically provided in the plan including:
    - outpatient disposable or consumable dental supplies.
    - personal supplies or tools, such as water piks or water jet devices, sonic devices, dental floss, toothbrushes, antibiotic rinses and toothpaste.
13. Preventive control programs, such as nutritional counseling, tobacco counseling and oral hygiene instruction.
14. In the event of circumstances not reasonably within our control, we shall not have any liability or obligation for delay or failure for the provision of dental services and/or treatment of you.
15. Experimental or Investigational procedures are not covered.
16. Services rendered by you, or any of your family members.

Notes:

Any Questions?

Prospective Members, call our Sales Department:
1-800-610-2660
TTY: 711
8 a.m.–8 p.m. local time, 7 days a week

Members, call our Customer Service Department:
1-888-867-5548
TTY: 711
8 a.m.–8 p.m. local time, 7 days a week

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