SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

SHL Dental PPO Plan 27 - Individual Adult Only Coverage

Attachment A Benefit Schedule

Please read the definition of Eligible Dental Expenses ("EDE") and SHL Reimbursement Schedule in the Certificate. When accessing a Non-Plan Dentist, you are responsible for any charges over EDE. Your Calendar year deductible for In-Plan Dentist Type II and Type III services is $50 per Insured, with a maximum of 3 per family. Your Calendar Year Deductible for Non-Plan Dentist Type II and Type III services is $50 per Insured, with a maximum of 3 per family. Your Calendar Year plan maximum benefit is $1,500 per Insured.

Type III Covered Services Waiting Period: You will not be eligible to receive any benefits for Type III Covered Services until you have been covered under this Certificate for 12 consecutive months. **Predetermination**: Predetermination is recommended for all Type III services. Please see Section 3 of your Dental Certificate for additional information about Predetermination.

Deductible Credit: Dental Expenses incurred by an individual on or after January 1st of the Calendar Year in which this Certificate becomes effective, will apply to the current Calendar Year Deductible for this plan if: 1) proof is furnished to SHL that such dental expenses were covered under the dental insurance policy in force immediately prior to the Effective Date of this Certificate; and 2) such expense would have been considered Covered Services under this Certificate had this Certificate been in force at the time expenses were incurred.

Covered Services and Limitations		Plan Dentist (No Calendar Year Deductible for Type I Services.) Insured pays:	Non-Plan Dentist (No Calendar Year Deductible for Type I Services.) Insured pays:
Type I Services: Diagnostic and Preventive			
Type I	Routine Evaluation (exams limited to twice (2) per Calendar Year)	0% of EDE	20% of EDE
Type I	Limited to Oral Evaluation – problem-focused/emergency	0% of EDE	20% of EDE
Type I	Detailed and Extensive Oral Evaluation – problem-focused (exam limited to specialist only, i.e. periodontal Exam)	0% of EDE	20% of EDE
Type I	Intraoral Radiograph – Complete Series or Panoramic Survey – Film (limited to one or the other, once every three (3) Calendar Year	0% of EDE	20% of EDE
Type I	Intraoral or Extraoral Radiographs	0% of EDE	20% of EDE
Type I	Bitewing Radiographs – (limited to twice (2) per Calendar Year)	0% of EDE	20% of EDE
Type I	Oral/facial images, Pulp Vitality Tests and Diagnostic Casts	0% of EDE	20% of EDE
Type I	Prophylaxis, Adult (limited to twice (2) per Calendar Year)	0% of EDE	20% of EDE
Type I	Recementation of Space Maintainer	0% of EDE	20% of EDE
Type II Services: Restorative (Includes local anesthesia and routine postoperative care)			
Type II	Restoration/Amalgam – per tooth (anterior & posterior teeth)	20% of EDE	40% of EDE
Type II	Restoration/Composite – per tooth (anterior & posterior teeth)	20% of EDE	40% of EDE
Type II	Recementation of Inlay, Crown or Bridge	20% of EDE	40% of EDE
Type II	Sedative Filling	20% of EDE	40% of EDE
Type II	Pin Retention – per tooth, in addition to restoration	20% of EDE	40% of EDE

Covered Services and Limitations		Plan Dentist (No Calendar Year Deductible for Type I Services.) Insured pays:	Non-Plan Dentist (No Calendar Year Deductible for Type I Services.) Insured pays:
Type II	Post Removal (not in conjunction with endodontic therapy)	20% of EDE	40% of EDE
Type II Services: Endodontics			
Type II	Pulp Cap - excluding final restoration	20% of EDE	40% of EDE
Type II	Therapeutic Pulpotomy, excluding final restoration	20% of EDE	40% of EDE
Type II	Pulpal Therapy, per primary tooth	20% of EDE	40% of EDE
Type II	Root Canal Therapy - initial or re-treatment, per tooth - *Note: Root Canals include intra-operative radiographs; excludes final restoration.*	20% of EDE	40% of EDE
Type II	Retrograde Filling – per root	20% of EDE	40% of EDE
Type II	Root Amputation – per root	20% of EDE	40% of EDE
Type II	Hemisection (including root removal) not including root canal therapy	20% of EDE	40% of EDE
Type II Services: Periodontics			
Type II	Gingivectomy or Gingivoplasty – per quadrant	20% of EDE.	40% of EDE.
Type II	Gingivectomy or Gingivoplasty – per tooth	20% of EDE.	40% of EDE.
Type II	Gingival Curettage, surgical – per quadrant	20% of EDE.	40% of EDE.
Type II	Gingival Flap Procedure (including Root Planing) – per quadrant	20% of EDE.	40% of EDE.
Type II	Clinical Crown Lengthening	20% of EDE.	40% of EDE.
Type II	Osseous Surgery – (including flap entry and closure)	20% of EDE.	40% of EDE.
Type II	Free Soft Tissue Graft Procedure (including donor site surgery)	20% of EDE.	40% of EDE.
Type II	Periodontal Scaling.Root Planing – per quadrant (limited to once (1) per quadrant per Calendar Year)	20% of EDE.	40% of EDE.

Covered Services and Limitations		Plan Dentist (No Calendar Year Deductible for Type I Services.) Insured pays:	Non-Plan Dentist (No Calendar Year Deductible for Type I Services.) Insured pays:
Type II	Full Mouth Debridement (limited to once in three (3) Calendar Years)	20% of EDE.	40% of EDE.
Type II	Periodontal Maintenance Procedure – following Active Therapy (limited to once in any three (3) month period)	20% of EDE.	40% of EDE.
Type II Services: Oral Surgery (includes local anesthesia and routine postoperative care)			
Type II	Simple Extraction – per tooth	20% of EDE.	40% of EDE.
Type II	Surgical Extraction – per tooth	20% of EDE.	40% of EDE.
Type II	Alveoloplasty – per quadrant	20% of EDE.	40% of EDE.
Type II	Removal of Exostosis – per site	20% of EDE.	40% of EDE.
Type II	Incision and Drainage of Abscess	20% of EDE.	40% of EDE.
Type II	Frenulectomy	20% of EDE.	40% of EDE.
Type II Services: Adjunctive General Services			
Type II	Excision of hyperplastic tissue – per arch	20% of EDE.	40% of EDE.
Type II	Sectioning of a bridge, to enable extraction of an abutment tooth	20% of EDE.	40% of EDE.
Type II	Adjustment to Denture of Partial, per appliance, per visit	20% of EDE.	40% of EDE.
Type II	Repair to Denture of Partial Denture, per repair, per appliance	20% of EDE.	40% of EDE.
Type II	Palliative (Emergency) treatment of dental pain – minor procedures	20% of EDE.	40% of EDE.
Type II	General Anesthesia or Intravenous Sedation when administered by the dentist in the office (when in connection with a surgical extraction or surgical procedure, or when Medically Necessary)	20% of EDE.	40% of EDE.
Type II	Professional Consultation (diagnostic service provided by dentist other than dentist providing treatment)	20% of EDE.	40% of EDE.
Type II	Office Visit after Regularly Scheduled Office Hours	20% of EDE.	40% of EDE.
Type II	Therapeutic Drug Injection	20% of EDE.	40% of EDE.

Covered Services and Limitations		Plan Dentist (No Calendar Year Deductible for Type I Services.) Insured pays:	Non-Plan Dentist (No Calendar Year Deductible for Type I Services.) Insured pays:
Type II	Other Drugs and/or Medicaments, by report	20% of EDE.	40% of EDE.
Type II	Application of Desensitizing Medicaments	20% of EDE.	40% of EDE.
Type II	Treatment of Complication (post-surgical), unusual circumstances	20% of EDE.	40% of EDE.
Type III Services: Prosthodontics – Removable (includes local anesthesia and routine postoperative care) **(Subject to 12 month waiting period)**			
Type III	Denture or Partial Denture, per appliance	50% of EDE	50% of EDE
Type III	Rebase Denture of Partial Denture (limited to once (1) per three (3) Calendar years, per appliance)	50% of EDE	50% of EDE
Type III	Reline Denture or Partial Denture, chairside process (limited to twice (2) per Calendar Year, per appliance)	50% of EDE	50% of EDE
Type III	Reline Denture or Partial Denture, laboratory process (limited to twice (2) per Calendar Year, per appliance)	50% of EDE	50% of EDE
Type III	Interim Partial Denture, replacing anterior teeth (temporary stayplate/flipper)	50% of EDE	50% of EDE
Type III	Tissue Conditioning (limited to twice (2) per Calendar Year per appliance)	50% of EDE	50% of EDE
Note: Adjustments are included in the cost of full and immediate dentures, partial dentures, relines and tissues conditionings within the first six (6) months after installation. Relines are allowed twice in a Calendar Year. Precision attachments, overdentures, specialized techniques and characterizations are considered optional and the additional expense shall be borne by the insured. All partials included conventional clasps and rests.			
Type III Services: Restorative and Prosthodontics – Fixed (includes local anesthesia and routine postoperative care) **(Subject to 12 month waiting period)**			
Type III	Inlay or Onlay each	50% of EDE	50% of EDE
Type III	Crown – per tooth	50% of EDE	50% of EDE
Type III	Core Buildup, including pins	50% of EDE	50% of EDE
Type III	Post and Core, in addition to crown	50% of EDE	50% of EDE
Type III	Temporary Crown, fractured tooth	50% of EDE	50% of EDE
Type III	Crown or Bridge Repair (by report)	50% of EDE	50% of EDE
Type III	Pontic – per tooth	50% of EDE	50% of EDE

Covered Services and Limitations		Plan Dentist (No Calendar Year Deductible for Type I Services.) Insured pays:	Non-Plan Dentist (No Calendar Year Deductible for Type I Services.) Insured pays:
Type III	Retainer (inlay/onlay) – per tooth	50% of EDE	50% of EDE
Type III	Retainer (crown/abutment) – per tooth	50% of EDE	50% of EDE

Note: Refer to the Certificate of Coverage for limitations, exclusions, Managed Care requirements and additional information about the covered services.