HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Dental Care G Plus Services Rider

This Rider is issued in consideration of: (a) the Groups's election of coverage under this Rider, (b) the Member's eligibility for the benefits described in this Rider, and (c) payment of any additional premium.

This Rider is a supplement to the Health Plan of Nevada ("HPN") Evidence of Coverage ("EOC") and Attachment A Benefit Schedule and amends your coverage to include benefits for Dental Services.

Section 1. Dental Care Services

1.1 Subject to all definitions, terms and conditions in this GEA, a Member is entitled to receive the Dental Care Services set forth in this Benefit Amendment. The Member shall be entitled to Dental Care Services only if such services are performed by a Participating Plan Dentist. A Participating Plan Dentist means those Dentists who have agreed under contract to participate in HPN's Preventive Dental Program and provide Preventive Dental Care Services to Members.

1.2 The maximum amount of benefits which Health Plan will provide under this Benefit Amendment is as follows: Two thousand dollars ($2,000.00) per Member per Calendar Year.

Section 2. Exclusions

In addition to any other applicable exclusions and/or limitations in the EOC, benefits shall not be provided for:

2.1 Prosthetic appliances used for the purpose of replacing an existing prosthetic appliance, if the Member has not been enrolled in Health Plan for a twelve (12) consecutive month period or if the existing prosthetic appliance is less than five (5) years old. The existing prosthetic appliance will be replaced only if the existing appliance cannot be made satisfactory.

2.2 Charges for the first installation of dentures and bridgework when the charges are for the replacement of natural teeth lost before the Member was covered under any Clark County sponsored Dental Program.

2.3 Services rendered by an employer's dental or medical department maintained by or on behalf of such employer.

2.4 Services provided by non-Participating Plan Dentists.

2.5 Services for which coverage is available under Workmen's Compensation or Employer's Liability laws.

2.6 Services provided or paid for by a governmental agency or under any governmental program or law, except charges which the Member is legally obligated to pay.

2.7 Services performed for cosmetic purpose or to correct congenital malformations.

2.8 Charges for coursed of treatment, including prosthetics, which were undertaken prior to the effective date of coverage.

2.9 Charges for services related to temporomandibular joint dysfunctions.

2.10 Loss or theft of a denture.

2.11 Charges for any treatment, installation of dentures, or any other services after termination of coverage, even if such treatment was initiated while any individual was covered hereunder.

2.12 Services, including general anesthesia not considered Medically Necessary by the dentist.

2.13 Restorations using gold foil and any precious metal restoration when the tooth can be restored using other filling materials.

2.14 Bonding for cosmetic purposes.

2.15 Any charges for services not specifically provided herein (including hospital services associated with any benefit in this amendment).

Section 3. General Provisions

The date upon which this Preventive Dental Care Services Benefit Amendment shall be effective is the date set forth in the GEA.

This Benefit Amendment shall terminate upon termination of the GEA and under the same terms and conditions specified in the GEA. Upon such termination, the Member covered under this Care Services Benefit Amendment shall cease to be entitled to any benefits provided herein.

Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, provisions, agreements or limitations of the attached EOC, other than as stated above in this Dental Care Services Benefit Amendment.

Covered Services and Limitations	Plan Benefit
Type I Services: Diagnostic and Preventive	
Routine Evaluation (exams limited to twice (2) per Calendar Year)	Member pays $0 per visit.
Full mouth x-rays (only if required, limited to once (1) per Calendar Year)	Member pays $0 per visit.
Prophylaxis, Adult or Child (limited to twice (2) per Calendar Year)	Member pays $0 per visit.
Space Maintenance Appliance (Allowed for the purposes of maintaining spaces created by extraction of primary teeth or unerupted teeth.)	Member pays $0 per visit.
Type II Services: Restorative (Includes local anesthesia and routine postoperative care)	
Restoration/Amalgam	Member pays $0 per visit.
Restoration/Composite – with reinforcing pin	Member pays $0 per visit.
Crowns, inlays and fixed prosthodontics	Member pays $25 per tooth or unit.
Cast-post and core	Member pays $0 per visit.
Recement inlays and crowns	Member pays $0 per visit.
Sedative fillings	Member pays $0 per visit.
Remove crown and decay	Member pays $0 per visit.
Type II Services: Endodontics	
Pulp Capping	Member pays $0 per visit.
Therapeutic Pulpotomy	Member pays $0 per visit.
Root Canal Therapy (excluding x-rays) One, two or three canals	Member pays $0 per visit.

Covered Services and Limitations	Plan Benefit
Type II Services: Periodontics	
Subgingival curettage and root planing, when performed by a general dentist	Member pays $0 per visit.
All other periodontal procedures	Member pays 20% of EDE
Type II Services: Oral Surgery (includes local anesthesia and routine postoperative care)	
Extractions, when performed by a general dentist	Member pays $5 per tooth
All other oral surgical procedures	Member pays 50% of EDE
Type III Services: Prosthodontics – Removable (includes local anesthesia and routine postoperative care) (Subject to 12 month waiting period)	
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.	
Complete and partial dentures	Member pays $25 per unit
Repair to dentures	Member pays $0 per visit.
Denture adjustments	Member pays $0 per visit.
Reline Denture or Partial Denture, chairside (limited to twice (2) per Calendar Year, per appliance)	Member pays $0 per visit.
Reline Denture or Partial Denture, laboratory process (limited to twice (2) per Calendar Year, per appliance)	Member pays $0 per visit.
Stress breaker	Member pays $0 per visit.
Precision attachment	Member pays $0 per visit.
Type III Orthodontic Services: (Subject to 12 month waiting period)	
Orthodontic Treatment Comprehensive (For a qualified dependent child who is age 8 or more but less than age 19 on the date the treatment commences, and who is covered for Dental Expense Coverage and if required by an overbite of at least four millimeters, crossbite, or protusive or retrusive realtionship of at least one cusp).	Member pays 20% of EDE