

EMBEDDED PEDIATRIC DENTAL* HMO BENEFIT SCHEDULE

Pediatric Dental Services for Members up to age 19



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Covered Services and Limitations	Pre-Determination Required	Tier I HMO Plan Provider Benefit
Diagnostic and Preventive <ul style="list-style-type: none"> Oral exam every six (6) months Periodic X-rays Diagnostic procedures Prophylaxis every six (6) months Topical fluoride treatment every six (6) months Sealants once per permanent molar Space maintenance therapy 	No	Not subject to CYD, Member pays 0% of EDE.
Restorative <ul style="list-style-type: none"> Amalgam or composite fillings as needed Crowns as needed Sedative fillings 	Yes	After CYD, Member pays 20% of EDE.
Endodontics <ul style="list-style-type: none"> Root canal therapy Pulpal therapy 	Yes	After CYD, Member pays 50% of EDE.
Periodontics <i>Limited to Members at least fourteen (14) years of age.</i>	Yes	After CYD, Member pays 50% of EDE.
Prosthodontics <ul style="list-style-type: none"> Partial and complete dentures <i>Limited to one unit once every sixty (60) months.</i> 	Yes	After CYD, Member pays 50% of EDE.
Orthodontics <i>Coverage provided for Medically Necessary Services only.</i>	Yes	After CYD, Member pays 50% of EDE.
Oral Surgery (includes Anesthesia) <ul style="list-style-type: none"> Extractions 	Yes	After CYD, Member pays 50% of EDE.
Emergency Dental Services <ul style="list-style-type: none"> Services or procedures necessary to control bleeding, relieve significant pain and/or eliminate acute infection. Services or procedures required to prevent pulpal death and/or imminent loss of teeth. 	No	After CYD, Member pays 50% of EDE.

PEDIATRIC DENTAL SERVICES ARE COVERED UNDER THE TIER I HMO BENEFIT ONLY

The pediatric dental benefit is embedded in a medical plan. The CYD is subject to the Medical Calendar Year Deductible, refer to the medical plan document for the deductible amount.

SECTION 1: EXCLUSIONS

This section tells you what services and supplies are not covered under the Evidence of Coverage. The following services and resulting complications are excluded from coverage hereunder.

- Any services and supplies not provided for in the Evidence of Coverage, not Medically Necessary as defined by the Evidence of Coverage or not required in accordance with the accepted standards of dental practice of the community.
- Services provided by non-participating dentists.
- Charges for services by a dental Plan Provider to his or her Dependents.
- Charges for care or services and supplies provided before the Effective Date or after the termination date of the Evidence of Coverage.
- Services or materials that are experimental or investigational.
- Services or materials provided under Workers' Compensation or Employer's Liability laws.
- Services provided or paid for by governmental agency or under any governmental program or law, except charges which the member is legally obligated to pay.
- Services performed for cosmetic purposes or to correct congenital malformations.
- Restorations using gold foil and any precious metal restoration when the tooth can be restored using other filling materials.
- Bonding for cosmetic purposes.
- Routine extractions for asymptomatic third (3rd) molar teeth.
- Routine extraction of loose deciduous teeth.
- Services and materials resulting from failure to comply with professionally prescribed treatment.
- Services or materials provided as a result of a self-inflicted injury or illness.
- Telephone consultations.

*Embedded Pediatric Dental is not included on Individual Health Plan of Nevada On-Exchange plans.

SECTION 2: GLOSSARY

This section tells you meanings of some of the more important words in the Evidence of Coverage. Please read it carefully. It will help you to understand the rest of the Evidence of Coverage.

- **“Calendar Year”** means January 1 through December 31 of the same year.
- **“Course of Treatment”** means an interdependent series of Medically Necessary Covered Services prescribed by a Dentist to correct a specific dental condition.
- **“Dentist”** means anyone qualified and licensed to practice dentistry who has a degree of Doctor or Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.).
- **“Dental Director”** means a Dentist designated by HPN to review the utilization of dental services by Members.
- **“Eligible Dental Expenses”** (“EDE”) means the maximum amount HPN will pay for a particular Covered Service as determined by HPN in accordance with HPN Reimbursement Schedule. Dental Plan Providers have agreed to accept HPN’s reimbursement as payment in full for Covered Services, less any applicable Copayment, Deductible or Coinsurance. In no event will HPN pay more than the maximum payment allowance established in the HPN Reimbursement Schedule.
- **“Emergency Dental Services”** means Covered Services provided after the sudden onset of a dental condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention could result in serious:
 - Jeopardy to his health;
 - Jeopardy to the health of an unborn child; Impairment of a bodily function; or
 - Dysfunction of any bodily organ or part.
- **“Injury”** means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical.
- **“Medically Necessary”** means any dental care services or supplies required to preserve the Member’s dental health and which, as determined by the Company’s Managed Care Program and or Dental Director, are:
 - (a) consistent with the symptoms or diagnosis and treatment of the Member’s dental deficiency;
 - (b) appropriate with regard to standards of good dental practice; and
 - (c) not solely for the convenience of the Member or Provider; and
 - (d) the most appropriate supply or level of service which can be provided to the Member.

Services, supplies, and accommodations will not automatically be considered Medically Necessary because they were prescribed by a Provider. The Company may consult with professional consultants, or other appropriate sources for recommendations regarding the services or supplies the Member receives are Medically Necessary.

- **“Non-Plan Provider”** means a Provider who does not have an independent contractor agreement with HPN.
- **“Occupational Illness or Injury”** means any Illness or Injury arising out of or in the course of employment for pay or profit.
- **“Plan Dentist”** means a Dentist who has an independent contractor agreement with HPN to provide Covered Services to Members.
- **“Predetermination”** means a system that requires a Provider to get approval from HPN before providing non-emergent healthcare services to a Member for those services to be considered Covered Services. Prior Authorization is not an agreement to pay for a service.
- **“Professional Service”** means examination, material selection, fitting of glasses, related adjustments, etc.



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Health plan coverage provided by Health Plan of Nevada.