Dental Insurance Summary

Dental Benefit Summary

Current		
Plan: LIN02 [1] / Type: VPPO		
	Benefit	**In/Out**
Plan Maximums	Annual In/Out of Network	NA / NA
	Ortho Lifetime	NA / NA
Deductible	Individual/Family	NONE / NONE
Waiting Period	Major Services	NO WAIT
	Preventive	100% / NA
	Minor Restore	NA / NA
Coinsurance	Endo/Perio/Oral*	NA / NA
	Major Services	NA / NA
	Orthodontia	NA / NA

Renewal		
Plan: LIN02 [1] / Type: VPPO		
	Benefit	**In/Out**
Plan Maximums	Annual In/Out of Network	NA / NA
	Ortho Lifetime	NA / NA
Deductible	Individual/Family	NONE / NONE
Waiting Period	Major Services	NO WAIT
	Preventive	100% / NA
	Minor Restore	NA / NA
Coinsurance	Endo/Perio/Oral*	NA / NA
	Major Services	NA / NA
	Orthodontia	NA / NA

Monthly Rates/ Premiums

	Enrollment	Rate
Employee	2	$9.49
Empl + Spouse	0	$18.98
Empl + Child	0	$24.15
Empl + Fam	1	$35.59
Monthly Premium	**$54.57**	

	Enrollment	Rate
Employee	2	$10.42
Empl + Spouse	0	$20.83
Empl + Child	0	$26.51
Empl + Fam	1	$39.06
Monthly Premium	**$59.90**	

Change from current: **9.8%**

- Dental plans have a 12 month rate guarantee. The rates displayed in this package will be effective through 12/31/2022. The rate guarantee is subject to change based upon changes to the policy and/or plan structure.

* Please refer to your benefit summary or certificate of coverage for a more detailed view of the benefit coverage for services within these categories as some plans may have benefits that differ from what we are able to display here.

[1] Ask about our Consumer Max Multiplier! This consumer driven benefit allows members to carry forward a portion of their unused annual dental maximum into an account for future use.

Vision Insurance Summary

Vision Benefit Summary

Current		
Plan: V1043 Type: VOLUNTARY		
	Services & Materials	**Amount**
In-Network Copay	Exam	$15
	Materials	$30
Frequencies	Exam	1 x per 12 mos
	Lenses	1 x per 12 mos
	Frames	1 x per 24 mos
Out-of-Network Reimbursement	Exam	Up to $40
	Single Lenses	Up to $40
	Bifocal Lenses	Up to $60
	Trifocal Lenses	Up to $80
	Lenticular Lenses	Up to $105
	Frames	Up to $45
	Elective Contacts	Up to $105

Renewal		
Plan: S1043 Type: VOLUNTARY		
	Services & Materials	**Amount**
In-Network Copay	Exam	$15
	Materials	$30
Frequencies	Exam	1 x per 12 mos
	Lenses	1 x per 12 mos
	Frames	1 x per 24 mos
Out-of-Network Reimbursement	Exam	Up to $40
	Single Lenses	Up to $40
	Bifocal Lenses	Up to $60
	Trifocal Lenses	Up to $80
	Lenticular Lenses	Up to $105
	Frames	Up to $45
	Elective Contacts	Up to $105

Monthly Rates/ Premiums

	Enrollment	Rate
Employee	2	$5.49
Empl + Spouse	0	$10.43
Empl + Child	1	$12.19
Empl + Fam	1	$17.18
Monthly Premium	**$40.35**	

	Enrollment	Rate
Employee	2	$5.49
Empl + Spouse	0	$10.43
Empl + Child	1	$12.19
Empl + Fam	1	$17.18
Monthly Premium	**$40.35**	

Change from current: **0.0%**

- Vision plans have a 24 month rate guarantee from contract issuance. The rates displayed within this package will be effective through 12/31/2022. The rate guarantee is subject to change based upon changes to the policy and/or plan structure.

Renewal Change Form

Policy number: 00X5452
Renewal date: 01/01/2022
Employer name: METASENSE INC.
403 COMMERCE LANE SUITE 5
WEST BERLIN, NJ 08091-0000

1 Specialty product selection:

UnitedHealthcare has a comprehensive product portfolio with a wide variety of plan options to meet your needs. In addition to dental, vision and life we also offer short-term and long-term disability plans. To request a specialty quote, reach out to your Renewal Account Executive.

	No Change	Add	Change	Plan name
Dental	☐	☐	☐	_____
	No Change	**Add**	**Change**	**Plan name**
Vision	☐	☐	☐	_____

2 Sign and send:

I understand that non-medical coverage, if any, will be insured by UnitedHealthcare Insurance Company or one of its affiliates.

Full legal name of employer/ firm: _____

Date signed: _____
(month/ day/ year)

Signed by: _____
(Employer signature)

Submit

Renewal change form

- Indicate coverage changes and submit your renewal change form by fax to 1-855-208-8348 by 12/12/2021, or e-mail us at plan_changes@uhc.com.
- If you have questions or wish to discuss your coverage options contact your broker or UnitedHealthcare representative at 1-866-432-5992.

UnitedHealthcare®
In Network Only Voluntary National Options PPO 15 Network

dental plan
LIN02 /MAC

	NETWORK
Individual Annual Deductible	$0
Family Annual Deductible	$0
Annual Maximum Benefit *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	
Annual Deductible Applies to Preventive and Diagnostic Services	No
Waiting Period	No waiting period

COVERED SERVICES*	NETWORK PLAN PAYS**	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES		
Periodic Oral Evaluation	100%	Limited to 2 times per consecutive 12 months.
Radiographs - Bitewing	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Radiographs - Intraoral/Extraoral	100%	Limited to 2 films per calendar year.
Lab and Other Diagnostic Tests	100%	
Dental Prophylaxis (Cleanings)	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	100%	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	100%	Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

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

*** The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan. The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above 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 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.

UnitedHealthcare Dental® Voluntary In Network Only (INO) Plan is either underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut; UnitedHealthcare Insurance Company of New York, Hauppage, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York; or United Healthcare Services, Inc.

UnitedHealthcare/dental exclusions and limitations

Dental Services described in this section are covered when such services are:

A. Necessary;
B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
C. The least costly, clinically accepted treatment; and
D. Not excluded as described in the Section entitled, General Exclusions.

GENERAL LIMITATIONS

1. **PERIODIC ORAL EVALUATION** Limited to 2 times per consecutive 12 months.
2. **COMPLETE SERIES OR PANOREX RADIOGRAPHS** Limited to 1 time per consecutive 36 months.
3. **BITEWING RADIOGRAPHS** Limited to 1 series of films per calendar year.
4. **EXTRAORAL RADIOGRAPHS** Limited to 2 films per calendar year.
5. **DENTAL PROPHYLAXIS** Limited to 2 times per consecutive 12 months.
6. **FLUORIDE TREATMENTS** Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
7. **SPACE MAINTAINERS** Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
8. **SEALANTS** Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

GENERAL EXCLUSIONS

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Placement of dental implants, implant-supported abutments and prostheses.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
22. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic Services.
25. Foreign Services are not Covered unless required as an Emergency.
26. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.