



Watkins Insurance

GROUP

July 26, 2013

Mineola Independent School District
Business Office: William Bjork
1000 W Loop
Mineola TX 75773

Dear Mr. Bjork

I appreciate again the opportunity to service and quote the Voluntary Dental benefits for Mineola ISD. Enclosed you will find your renewal with United HealthCare. Renewal options have been requested from UHC, and we are waiting on the underwriter to release those rates. I will forward the options with UHC as soon as I receive them. Principal, DentalSelect, AIG, and Delta Dental all provided quotes as well, however rates were higher than your current renewal, keeping with the preferred dental benefits that you currently have.

Feel free to call if you have any questions.

Sincerely,

Nichol Cook
Health & Life Agent
Watkins Insurance Group
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903-569-5110 (fax)
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MINEOLA
P.O. Box 1188
Mineola, TX 75773
903-569-5115
903-569-5110 (fax)

HOLLY LAKE/HAWKINS
2365 S. FM 2869, Ste. 2
Hawkins, TX 75765
903-769-3167
903-769-5566
903-769-9137 (fax)

LONGVIEW
3000 Gilmer Rd., Ste. 103
Longview, TX 75604
903-297-6787
903-297-6798 (fax)

TYLER
2220 Grande Blvd.
Tyler, TX 75703
903-509-2468
903-939-9990 (fax)

Dental
 Deductible
 Individual Deductible
 Family Deductible
 Waived for Preventative
 Preventative (Type I)
 Basic (Type II)
 Major (Type III)
 Annual Max

Ortho
 Co-Insurance
 Lifetime Max

Employee Only
 Employee/Spouse
 Employee/Children
 Employee/Family

UHC	
Current Plan	
Lifetime	
\$100	
yes	
100%	
80%	
50%	
\$1,250	
Child only to 19	
50%	
\$1,200	
Current	Renewal
43.77	46.62
92.81	98.85
87.54	93.24
141.08	150.26

UnitedHealthcare Dental®
Options PPO/covered dental services

dental plan
P3421

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Lifetime Individual Deductible	\$100	\$100	None	None
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.)	\$1250 per person per calendar year	\$1250 per person per calendar year	\$1200 per person per lifetime	\$1200 per person per lifetime
Lifetime deductible applies to preventive and diagnostic services	No			
Lifetime deductible applies to orthodontic services	No			
Waiting Period	12 months for major and orthodontic services			
Orthodontia eligibility requirement	Children under age 19			

COVERED SERVICES*	NETWORK	NON-NETWORK	BENEFIT GUIDELINES
	PLAN PAYS**	PLAN PAYS***	
PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES			
Periodic Oral Examinations	100%	100%	Limited to 2 times per consecutive 12 months.
Bite-Wing X-rays	100%	100%	One series of films per calendar year.
Complete Series or Panorex X-rays	100%	100%	Limited to one time per consecutive 36 months.
Dental Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	100%	100%	Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
BASIC DENTAL SERVICES			
Space Maintainers	80%	80%	For covered persons under the age of 16 years, once per lifetime.
Palliative Treatment (Relief of Pain)	80%	80%	Covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.
General Anesthesia	80%	80%	When medically necessary.
Amalgam Restorations (Fillings)	80%	80%	Multiple restorations on one surface will be treated as a single filling.
Composite Restorations (Fillings)	80%	80%	Multiple restorations on one surface will be treated as a single filling. For anterior teeth only.
Simple Extraction	80%	80%	
Surgical Extraction including Impacted Wisdom Teeth	80%	80%	
Root Canal Treatment	80%	80%	
Scaling and Root Planing	80%	80%	Limited to one time per quadrant per consecutive 24 months.
Periodontal Surgery	80%	80%	Limited to once every consecutive 36 months per surgical area.
Periodontal Maintenance	80%	80%	Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement.
MAJOR DENTAL SERVICES			
Crowns, Inlays, and Onlays	50%	50%	Limited to one time per tooth per consecutive 60 months.
Fixed Bridges	50%	50%	Once per tooth per consecutive 60 months. Alternate benefits for a partial denture may be applied.
Full Dentures	50%	50%	Once per consecutive 60 months. No allowance for overdentures or customized dentures.
Partial Dentures	50%	50%	Once per consecutive 60 months. No allowance for precision or semi-precision attachments.
Recement Bridges, Crowns, Inlays	50%	50%	
Relining and Rebasing Dentures	50%	50%	Limited to one time every consecutive 12 months, and limited to relining done more than 6 months after the initial insertions.
Repairs to Full Dentures, Partial Dentures, Bridges	50%	50%	Limited to repairs or adjustments performed more than 12 months after the initial insertion.
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	Course of treatment is typically 24 months, with initial payment at banding of 20% and remaining payment spread equally over the course of treatment.

* 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 \$200; 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 schedule of reasonable and customary charges in the geographic area in which the expenses are incurred.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table 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 of 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® Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; or United HealthCare Services, Inc.