OBM Basic Specialty Option

With the OBM Basic Specialty Option, members receive insured dental, discounted vision, health discounts, work & life services with EAP and an optional basic employee life product. Please see below for a listing of some of the benefits and services that are included.

Participation Requirements	**75% participating less valid waivers, not to fall below 50% of all eligible employees**
Contribution Requirements	**Minimum 50% employer paid**

DENTAL

	IN-NETWORK	OUT OF NETWORK (MAC)[1]
Plan Type	Passive PPO	
Coinsurance	100/Discount/Discount	100/0/0
Annual Maximum	$1,000	$1,000
Deductible		
Single	N/A	N/A
Family	N/A	N/A
Preventive & Diagnostic	100%	100%
Minor Restorative	Discount[2]	0%
Endodontics/Periodontics/Oral Surgery	Discount[2]	0%
Major Care	Discount[2]	0%
Orthodontia (Optional)	N/A	N/A
Waiting Periods	None	None

VISION

	IN-NETWORK	OUT OF NETWORK
Eye Exams (every 12 months)	$10 copay	Not covered
Materials	Unlimited frequency	Not covered
Lenses	$45/$65/$95 copay	Not covered
Frames	30% off retail frame price 10% at in-network Walmart locations	Not covered
Contacts	20% discount at private practice providers	Not covered

EMPLOYEE ASSISTANCE PROGRAM WITH WORKLIFE SERVICES

Support services that offer unlimited telephone consultation, personalized referrals, online resources and services, and educational resources on a wide variety of subjects, including Child/Parenting Support Services, Adult/Elder Support Services, Chronic Condition Support Services and much more.

HEALTH DISCOUNT PROGRAM

A discount program offering savings of 5% to 50% on health-related products and services.

Vision: 5% – 50% Off
- Eye exams, LASIK Eye Surgery, Optical Products

Dental: 10% – 35% Off
- General Dentistry, Cosmetic Dentistry, Orthodontia

Alternative Medicine: 20% Off
- Chiropractic, Massage Therapy, Acupuncture

Wellness: 10% – 50% Off
- Fitness, Smoking Cessation, Nutrition

Long Term Care: 5% – 30% Off
- Home Health Care, DME, Hospice

Hearing: 20% – 60% Off MSRP
- Testing and Hearing Devices

Infertility: 12% – 33% Off
- In-Vitro Fertilization, Fertility Medications

BASIC EMPLOYEE LIFE (Optional)

An optional term life insurance product is available as a buy up feature to the OBM Specialty Options.

Disclosure: The UnitedHealth Allies® discount plan is administered by HealthAllies®, Inc., a discount medical plan organization. **The UnitedHealth Allies discount plan is NOT insurance.** The UnitedHealth Allies discount plan provides discounts at certain health care providers for medical services. The discount plan does not make payments directly to the providers of medical services. The discount plan member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount plan organization. HealthAllies, Inc., is located at P.O. Box 10340, Glendale, CA 91209, 1-800-860-8773, www.unitedhealthallies.com, ohacustomercare@optumhealth.com.

[1] Out-of-network benefits are paid based on UnitedHeathcare Dental's Maximum Allowable Charge (MAC) schedule.
[2] In-network basic and major care is discounted through the UnitedHealth Allies Health Discount Program.

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. Series or panorex radiographs limited to 1 time per consecutive 36 months. Exception to this limit will be made for panorex radiographs if taken for diagnosis of third molars, cysts, or neoplasms.
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. Treatment should be done in conjunction with dental prophylaxis.
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.
9. Restorations multiple restorations on one surface will be treated as a single filling.
10. Pin retention limited to 2 pins per tooth; not covered in addition to cast restoration.
11. Inlays and onlays limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
12. Crowns limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
13. Post and cores covered only for teeth that have had root canal therapy.
14. Sedative fillings 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.
15. Scaling and root planing limited to 1 time per quadrant per consecutive 24 months.
16. Periodontal maintenance limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
17. Full dentures limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
18. Partial dentures limited to 1 time every consecutive 60 months. No additional allowances for precision or semi precision attachments.
19. Relining and rebasing dentures limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
20. Repairs to full dentures, partial dentures, bridges
21. Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
22. Palliative treatment covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
23. Occlusal guards limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.
24. Full mouth debridement limited to 1 time every consecutive 36 months.
25. General anesthesia covered only where clinically necessary.
26. Osseous grafts limited to 1 per quadrant or site per consecutive 36 months.
27. Periodontal surgery hard tissue and soft tissue periodontal surgery are limited to 1 per quadrant or site per consecutive 36 months per surgical area.
28. Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

General Exclusions

The following are not covered:

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 which 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 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

Vision Exclusions

The following Services and materials are excluded from coverage under the Policy:

1. Non-prescription items (e.g. Plano lenses).
2. Services that the Covered Person, without cost, obtains from any governmental organization or program.
3. Services for which the Covered Person may be compensated under Worker's Compensation Law, or other similar employer liability law.
4. Any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.
5. Medical or surgical treatment for eye disease, which requires the services of a physician.
6. Expenses incurred pr ior to meeting the Deductible.
7. Expenses incurred in excess of the Maximum Annual Benefit.
8. Expenses incurred in excess of the Maximum Policy Benefit.
9. Replacement or repair of lenses and/or frames that have been lost or broken.
10. Optional Lens Extras not listed in the Table of Benefits.
11. Missed appointment charges.
12. Applicable sales tax charged on Services.
13. Services that are not specifically covered by the Policy.
14. Procedures that are considered to be Experimental, Investigational or Unproven. 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.

Life Exclusions and Limitations:

1. Engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, mountain climbing, Russian Roulette, autoerotic asphyxiation or bungee jumping;
2. Injury arising out of or in the course of any occupation or employment for pay profit, or any Injury or Sickness for which the Covered Person is entitled to benefits under any Workers Compensation Law, Employers Liability Law or similar law, unless this insurance is issued on an occupational (24 hour) basis as shown in the Schedule of Benefits;
3. Travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people.

* Some limitations may be modified or omitted as a result of certain State regulations or requirements.

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