UnitedHealthcare®
National Options PPO 20 Network/covered dental services

dental plan
1P891 /FS22

	NETWORK	NON-NETWORK
Individual Annual Deductible	$0	$0
Family Annual Deductible	$0	$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.)*	$1000 per person per Calendar Year	$1000 per person per Calendar Year
Annual Deductible Applies to Preventive and Diagnostic Services	No	
Waiting Period	No waiting period	

COVERED SERVICES*	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	$25.00	Limited to 2 times per consecutive 12 months.
Radiographs - Bitewing	100%	$11.00	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Radiographs - Intraoral/Extraoral	100%	$75.00	Limited to 2 films per calendar year.
Lab and Other Diagnostic Tests	100%	$72.00	
Dental Prophylaxis (Cleanings)	100%	$52.00	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	100%	$31.00	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	100%	$27.00	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%	$212.00	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
MAJOR DENTAL SERVICES			

* 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. For a complete list of amounts, please refer to your Certificate of Coverage
Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for Veneers, please refer to your Certificate of Coverage
Cone Beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for Cone Beams, please refer to your Certificate of Coverage

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® Options PPO 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.
9. RESTORATIONS (Amalgam or Composite) 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, ONLAYS, AND VENEERS 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. ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.
17. PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.
18. FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
19. PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
20. 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.
21. REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES 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 covered if prescribed to control habitual grinding.
24. FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.
25. GENERAL ANESTHESIA Covered only when 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 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.
29. CONE BEAM Limited to 1 time per consecutive 60 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.

GENERAL EXCLUSIONS

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. This exclusion does not apply for groups situsedin the state of Arizona, in order to comply with state regulations.
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.

ADA Code and Description	Plan Pays
D0120 PERIODIC ORAL EVALUATION EST PT	$25.00
D0140 LTD ORAL EVALUATION - PROBLEM FOCUS	$40.00
D0145 ORAL EVAL PT<3 AND COUNSEL	$31.00
D0150 COMP ORAL EVALUATION - NEW/EST PT	$36.00
D0160 DTL&EXT ORAL EVAL - PROB FOCUS RPT	$71.00
D0170 RE-EVALUATION - LTD PROBLEM FOCUSED	$32.00
D0180 COMP PERIODONTAL EVAL - NEW/EST PT	$33.00
D0210 INTRAORAL-COMPLETE SERIES RADIOGRAPHIC IMAGES	$75.00
D0220 INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$13.00
D0230 INTRAORL PERIAPICAL EA ADD RADIOGRAPHIC IMAGE	$10.00
D0240 INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$19.00
D0250 EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	$30.00
D0251 EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	$30.00
D0270 BITEWING - SINGLE RADIOGRAPHIC IMAGE	$11.00
D0272 BITEWINGS - TWO RADIOGRAPHIC IMAGE	$21.00
D0273 BITEWINGS - THREE RADIOGRAPHIC IMAGE	$27.00
D0274 BITEWINGS - FOUR RADIOGRAPHIC IMAGE	$32.00
D0277 VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGE	$46.00
D0330 PANORAMIC RADIOGRAPHIC IMAGE	$59.00
D0350 2D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY	$35.00
D0351 3D PHOTOGRAPHIC IMAGE	$35.00
D0414 LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	$72.00
D0415 COLLECT MICROORAGNISMS CULT & SENS	$72.00
D0416 VIRAL CULTURE	$72.00
D0431 ADJUNCT PREDX TST NO CYTOL/BX PROC	$46.00
D0460 PULP VITALITY TESTS	$25.00
D0470 DIAGNOSTIC CASTS	$55.00
D0601 CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	$31.00
D0602 CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	$31.00
D0603 CARIES RISK ASSESSMENT AND DOCUMENTATION, HIGH	$31.00
D1110 PROPHYLAXIS - ADULT 1	$52.00
D1120 PROPHYLAXIS - CHILD 1	$39.00
D1206 TOP FLUORIDE VARNISH	$31.00
D1208 TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	$25.00
D1351 SEALANT - PER TOOTH	$27.00
D1352 PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	$27.00
D1353 SEALANT REPAIR – PER TOOTH	$13.50
D1510 SPACE MAINTAINER - FIXED-UNILATERAL	$212.00
D1515 SPACE MAINTAINER - FIXED-BILATERAL	$322.00

D1520 SPACE MAINTAINER - REMOVABLE-UNI	$264.00
D1525 SPACE MAINTAINER - REMOVABLE-BIL	$348.00
D1550 RECEMENT OR RE-BOND SPACE MAINTAINER	$33.00
D1555 REMOVAL OF FIXED SPACE MAINTAINER	$33.00
D1575 DISTAL SHOE SPACE MAINTAINER – FIXED – UNILATERAL	$212.00