

# UnitedHealthcare Dental® Consumer MaxMultiplier - Options PPO/covered dental services

dental plan  
P4216

	NETWORK	NON-NETWORK
Individual Annual Deductible	\$50	\$50
Family Annual Deductible	\$150	\$150
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.)	\$2000 per person per calendar year	\$2000 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
<b>PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES</b>			
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.
<b>BASIC DENTAL SERVICES</b>			
Space Maintainers	90%	80%	For covered persons under the age of 16 years, once per lifetime.
Palliative Treatment (Relief of Pain)	90%	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	90%	80%	When medically necessary.
Amalgam Restorations (Fillings)	90%	80%	Multiple restorations on one surface will be treated as a single filling.
Composite Restorations (Fillings)	90%	80%	Multiple restorations on one surface will be treated as a single filling. For anterior teeth only.
Simple Extraction	90%	80%	
Surgical Extraction including Impacted Wisdom Teeth	90%	80%	
Root Canal Treatment	90%	80%	
Scaling and Root Planing	90%	80%	Limited to one time per quadrant per consecutive 24 months.
Periodontal Surgery	90%	80%	Limited to once every consecutive 36 months per surgical area.
Periodontal Maintenance	90%	80%	Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement.
<b>MAJOR DENTAL SERVICES</b>			
Crowns, Inlays, and Onlays	60%	50%	Limited to one time per tooth per consecutive 60 months.
Fixed Bridges	60%	50%	Once per tooth per consecutive 60 months. Alternate benefits for a partial denture may be applied.
Full Dentures	60%	50%	Once per consecutive 60 months. No allowance for overdentures or customized dentures.
Partial Dentures	60%	50%	Once per consecutive 60 months. No allowance for precision or semi-precision attachments.
Recent Bridges, Crowns, Inlays	60%	50%	
Relining and Rebasing Dentures	60%	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	60%	50%	Limited to repairs or adjustments performed more than 12 months after the initial insertion.

\* This plan includes a maximum benefit award program. Some of the unused portion of your annual maximum benefit may be available in future benefit periods.

\*\* 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.

# UnitedHealthcare/dental exclusions and limitations

## GENERAL LIMITATIONS

**ORAL EXAMINATIONS** Covered as a separate benefit only if no other service was performed during the visit other than prophylaxis and X-rays. Limited to 2 times per consecutive 12 months.

**COMPLETE SERIES OR PANOREX RADIOGRAPHS** Limited to one 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.

**BITEWING RADIOGRAPHS** Limited to 1 series of films per calendar year.

**EXTRAORAL RADIOGRAPHS** Limited to 2 films per calendar year.

**DENTAL PROPHYLAXIS** Limited to 2 times per consecutive 12 months.

**DIAGNOSTIC CASTS** Limited to one time per consecutive 24 months.

**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.

**SEALANTS** Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

**SPACE MAINTAINERS** Limited to covered persons under the age of 16 years, once per lifetime. Benefit includes all adjustment within 6 months of installation.

**RESTORATIONS** Multiple restorations on one surface will be treated as a single filling. Composite restorations limited to anterior teeth only.

**PIN RETENTION** Limited to 2 pins per tooth; not covered in addition to Cast Restoration.

**INLAYS AND ONLAYS** Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

**CROWNS** Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

**POST AND CORES** Covered only for teeth that have had root canal therapy.

**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.

**SCALING AND ROOT PLANING** Limited to 1 time per quadrant per consecutive 24 months.

**PERIODONTAL MAINTENANCE** Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement.

**FULL DENTURES** Limited to once every consecutive 60 months. No additional allowances for overdentures or customized dentures.

**PARTIAL DENTURES** Limited to once every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

**RELINING AND REBASING DENTURES** Limited to relining or rebasing performed more than 6 months after the initial insertions. Limited to 1 time per consecutive 12 months.

**REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES** Limited to repairs or adjustments performed more than 12 months after the initial insertion.

**PALLIATIVE TREATMENT** 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.

**OCCUSAL GUARDS** Covered only if prescribed to control habitual grinding, and limited to one guard every consecutive 36 months.

**FULL MOUTH DEBRIDEMENT** Limited to once every consecutive 36 months.

**GENERAL ANESTHESIA** Covered only where medically necessary.

**OSSEOUS GRAFTS** With or without resorbable GTR membrane replacement, are limited to once every consecutive 36 months per quadrant or surgical site.

**PERIODONTAL SURGERY** Hard tissue and soft tissue periodontal surgery are limited to once every consecutive 36 months, per surgical area. This includes gingivectomy, gingivoplasty, gingival flap procedure, osseous surgery, pedicle grafts, and free soft tissue grafts.

### REPLACEMENT OF FULL DENTURES, PARTIAL DENTURES, BRIDGES, OR CROWNS

Replacement of complete or partial dentures, both fixed and removable, or crowns, previously submitted for payment under this Plan is limited to once every 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 is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the Covered Person's eligibility with the Plan.
10. 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.
11. 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.
12. Dental Services provided in a foreign country, unless required as an Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been eligible for 12 continuous months.
15. Replacement of complete or partial dentures, crowns, or fixed bridgework 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.
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. Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
20. Placement of fixed bridgework solely for the purpose of achieving periodontal stability.
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision.
23. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
24. 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.
25. Acupuncture; acupressure and other forms of alternative treatment.
26. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
27. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.