

United HealthCare Services, Inc. (20020)® Contributory Options PPO 30 / covered dental services		NON-ORTHODONTICS		ORTHODONTICS	
		NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible		\$50	\$50	\$0	\$0
Family Annual Deductible		\$150	\$150	\$0	\$0
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum)		\$2,000 per person per Calendar Year	\$2,000 per person per Calendar Year	\$2,000 per person per Lifetime	\$2,000 per person per Lifetime
New enrollee's waiting period		None			
Annual deductible and annual maximum benefit applies to preventive and diagnostic					No
Annual Deductible Applies to Orthodontic Services					No
Orthodontic Eligibility Requirement					Adult & Child
CMM-Annual Roll-Over					Yes
COVERED SERVICES *		NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES	
DIAGNOSTIC SERVICES					
Periodic Oral Evaluation		100%	100%	See Exclusions and Limitations section for benefit guidelines.	
Radiographs		100%	100%		
Lab and Other Diagnostic Tests		100%	100%		
PREVENTIVE SERVICES					
Prophylaxis (Cleaning)		100%	100%	See Exclusions and Limitations section for benefit guidelines.	
Fluoride Treatment (Preventive)		100%	100%		
Sealants		100%	100%		
Space Maintainers		100%	100%		
BASIC SERVICES					
Restorations (Amalgams or Composite)		80%	80%	See Exclusions and Limitations section for benefit guidelines.	
Emergency Treatment/General Services		80%	80%		
Simple Extractions		80%	80%		
Oral Surgery (incl. surgical extractions)		80%	80%		
Periodontics		80%	80%		
Endodontics		80%	80%		
MAJOR SERVICES					
Inlays/Onlays/Crowns		50%	50%	See Exclusions and Limitations section for benefit guidelines.	
Dentures and Removable Prosthetics		50%	50%		
Fixed Partial Dentures (Bridges)		50%	50%		
ORTHODONTIC SERVICES					
Diagnose or correct misalignment of the teeth or bite		50%	50%		

This plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future 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 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 fees negotiated with the provider.

***The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

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 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; 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.

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