UnitedHealthcare®

FlexAppeal Enhanced dental plan

Consumer MaxMultiplier Voluntary National Options PPO 20 Network/covered dental services

1X737 /MAC

	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	$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%	100%	Limited to 2 times per consecutive 12 months.
Radiographs - Bitewing	100%	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Radiographs - Intraoral/Extraoral	100%	100%	Limited to 2 films per calendar year.
Lab and Other Diagnostic Tests	100%	100%	
Dental Prophylaxis (Cleanings)	100%	100%	Benefit is not to exceed in combination with periodontal maintenance 4 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.
Space Maintainers	100%	100%	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
Restorations; Amalgam or Composite (Anterior & Posterior)	90%	80%	Multiple restorations on one surface will be treated as a single filling.
General Services - Emergency Treatment	90%	80%	Covered as a separate benefit only if no other service was done during the visit other than X-rays.
General Services - Occlusal Guards	90%	80%	Limited to 1 guard every consecutive 36 months.
General Services - Anesthesia	90%	80%	When clinically necessary.
Simple Extractions	90%	80%	Limited to 1 time per tooth per lifetime.
Oral Surgery - Brush Biopsy	90%	80%	
Oral Surgery - Surgical Extractions	90%	80%	
Oral Surgery - Partial/Bony	90%	80%	
Oral Surgery - Other	90%	80%	
Endodontics - Pulpotomy	90%	80%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
Endodontics - Other	90%	80%	
Periodontal Maintenance	90%	80%	Benefit is not to exceed in combination with dental prophylaxis 4 per consecutive 12 months.
Periodontics - Non Surgical	90%	80%	Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months.
Periodontics - Surgical	90%	80%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
Periodontics - Osseous Surgery	90%	80%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
MAJOR DENTAL SERVICES			
Inlays/Onlays/Crowns**	60%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	60%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)**	60%	50%	Limited to 1 time per tooth per consecutive 60 months.
Implant Services	60%	50%	Limited to 1 time per tooth per consecutive 60 months.

* 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 $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.

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® Voluntary 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.

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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. Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. 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.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. 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.
13. 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.
14. 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.
15. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
16. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
17. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
18. 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 o this nature.
19. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

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GENERAL EXCLUSIONS

20. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
21. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
22. 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.
23. 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 th date individual Coverage under the Policy terminates.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
26. Foreign Services are not Covered unless required as an Emergency.
27. 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.
28. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.

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