

P3963
Dental Options PPO
Covered Dental Services (Custom-With Orthodontics)

	Non-Orthodontics		Orthodontics	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Annual Deductible	\$50	\$50	\$0	\$0
Family Annual Deductible	\$150	\$150	\$0	\$0
Maximum (combined for both In-Network and Out-of-Network services)	\$ 1000 per person per calendar year	\$ 1000 per person per calendar year	\$ 1000 per person per lifetime	\$ 1000 per person per lifetime

	In-Network	Out-Of-Network
Annual deductible applies to preventive and diagnostic services	No	No
Annual deductible applies to orthodontic services	No	No
This plan has no waiting periods.		
Orthodontic eligibility requirement	Child (up to age 19)	

Covered Services	In-Network Plan Pays*	Out-of-Network Plan Pays*	Benefit Guidelines
Preventive and Diagnostic Dental Services			
Periodic Oral Examinations	100%	100%	Covered as a separate benefit only if no other service was done during the visit other than X-rays. Limited to 2 times per consecutive 12 months.
Bitewing X-rays	100%	100%	Limited to 1 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. Treatment should be done in conjunction with dental prophylaxis.
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%	Limited to Covered Persons under the age of 16 years, once per lifetime. Benefit includes all adjustment within 6 months of installation.
Basic Dental Services			
Amalgam Restorations (Fillings)	80%	80%	Multiple restorations on one surface will be treated as a single filling.
Composite Resin Restorations (Fillings)	80%	80%	Multiple restorations on one surface will be treated as a single filling.

Root Canal Treatment	80%	80%	
Simple Extraction	80%	80%	
Surgical Extraction including Impacted Wisdom Teeth	80%	80%	
General Anesthesia	80%	80%	When clinically necessary
Palliative Treatment (Relief of Pain)	80%	80%	Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.
Major Dental Services			
Root Planing	50%	50%	Limited to 1 time per quadrant per consecutive 24 months.
Periodontal Surgery	50%	50%	Once in any 36 month period.
Crowns	50%	50%	Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
Fixed Bridges	50%	50%	Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. (alternate benefits for a partial denture may be applied)
Full Dentures	50%	50%	Once every 60 months. No additional allowances for over-dentures or customized dentures.
Inlays and Onlays	50%	50%	Limited to one time per tooth per consecutive 60 months. Covered only when silver fillings cannot restore the tooth.
Partial Dentures	50%	50%	Once every 60 months. No additional allowances for precision or semi precision attachments.
Recement Bridges, Crowns and Inlays	50%	50%	Once every 6 months per restoration
Relining Dentures	50%	50%	Limited to relining done more than 6 months after the initial insertions. Limited to 1 time per consecutive 12 months.
Repairs to Full Dentures, Partial Dentures, Bridges	50%	50%	Limited to repairs or adjustments done more than 12 months after the initial insertion.
Orthodontic Services			
Diagnose or correct misalignment of the teeth or bite including Phase I and Phase II	50%	50%	Preauthorization required

**The in-network percentage of benefits is based on the discounted fee negotiated with the provider.*

***The out-of-network percentage of benefits is paid at 85th percentile of the usual and customary rates prevailing 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.