UnitedHealthcare Insurance Company

LOW PPO

Dental Plan
New Standard/021P1/MAC

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$100	$0	$0
Family Annual Deductible	$150	$300	$0	$0
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum)	$1,000 per person per Calendar Year	$500 per person per Calendar Year	$1,000 per person per Lifetime	$1,000 per person per Lifetime
New enrollee's waiting period	None			

Annual deductible applies to preventive and diagnostic services	Yes (In Network	Yes (Out Network)
Annual Deductible Applies to Orthodontic Services	No	
Orthodontic Eligibility Requirement	Child Only (Up to Age 19)	
CMM-Annual Roll-Over	Yes	

COVERED SERVICES *	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	80%	See Exclusions and Limitations section for benefit guidelines.
Radiographs	100%	80%	
Lab and Other Diagnostic Tests	100%	80%	
PREVENTIVE SERVICES			
Prophylaxis (Cleaning)	100%	80%	See Exclusions and Limitations section for benefit guidelines.
Fluoride Treatment (Preventive)	100%	80%	
Sealants	100%	80%	
Space Maintainers	100%	80%	
BASIC SERVICES			
Restorations (Amalgams or Composite)	70%	50%	See Exclusions and Limitations section for benefit guidelines.
Emergency Treatment/General Services	70%	50%	
General Services - Adjunctive Occlusal Guard	70%	50%	Emergency Treatment and General Services that fall under Restorations, Amalgams or Composites will be covered at this benefit level
General Services - Adjunctive Emergency Treatment	70%	50%	
General Services - Adjunctive Other	70%	50%	
Simple Extractions	70%	50%	
MAJOR SERVICES			
Emergency Treatment/General Services	40%	20%	See Exclusions and Limitations section for benefit guidelines.
General Services - Adjunctive Anesthesia	40%	20%	
Oral Surgery (incl. surgical extractions)	40%	20%	Emergency Treatment and General Services that fall under Oral Surgery, Periodontics, Endodontics, Crowns, Dentures and Dentures will be covered at this benefit level.
Periodontics	40%	20%	
Endodontics	40%	20%	
Inlays/Onlays/Crowns	40%	20%	
Dentures and Removable Prosthetics	40%	20%	
Fixed Partial Dentures (Bridges)	40%	20%	
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	25%	

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 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 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.

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 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.
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 sitused in 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 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.
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.
27 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

Get rewarded for taking care of your smile

Our Consumer MaxMultiplier® program rewards you for keeping up with your dental care by adding dollars to next year's annual maximum. It's included as part of your dental plan.

How the program works

Earn award dollars for visiting your dentist at least once a year.[1]

Your award dollars will help to pay for claims that go beyond your annual maximum.

Unused award dollars can roll over each year.

Earn up to

$225

to add to your 500 annual maximum

Award dollars can add up

Here's an example of the award dollars you could earn if you visit your dentist at least once this year:

This year's annual maximum is	If your total claims are less than	You'll earn a reward of
$500	$250	$125

Plus, if you have a Dental PPO plan and all claims are with network dentists, you'll earn an extra $100. Your award dollars will be added to next year's annual maximum to pay for qualifying claims. To view your annual maximum balance, log in to **myuhc.com®.**

continued

United Healthcare

Program rules

1. $500 is the most award dollars that can be rolled over to the annual maximum. The total annual maximum cannot go above $1,000.
2. If your plan has different annual network and out-of-network maximums, the award dollars will be based on the annual out-of-network maximum. Award dollars are added to your annual maximum the following year.
3. Award dollars can be used for claims filed up to 180 days after your benefit period ends.
4. Award dollars can be used for both network and out-of-network claims.
5. Award dollars do not apply to orthodontic services.
6. If you sign up for a UnitedHealthcare Dental PPO or Dental In-Network Only (INO) plan in the last 3 months of a benefit period, you will have to wait until the end of the first full month of the next benefit period to participate in this program.
7. If you end your coverage, but sign up again within 6 months with the same employer, you can keep your award balance as long as your employer still offers a dental plan with Consumer MaxMultiplier. If 6 months or more pass, you will lose the award balance.
8. If your employer decides to change your dental plan, your award balance will move with you as long as the new plan includes Consumer MaxMultiplier.

Questions? Call the member phone number on your digital ID card

United Healthcare

[1] You will not actually earn cash that you can access or withdraw. UnitedHealthcare adds the award dollars to your annual maximum for the following year and applies them to qualifying claims.

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

This program may not be available in all states. Components subject to change.

This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact either your broker or the company.

UnitedHealthcare dental coverage underwritten by UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), DBP Services (NY only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.06.TX, DPOL.12.TX and DPOL.12.TX (Rev. 9/16) and associated COC form numbers DCOC.CER.06, DCOC.CER.IND.12.TX and DCERT.IND.12.TX. Plans sold in Virginia use policy form number DPOL.06.VA with associated COC form number DCOC. CER.06.VA and policy form number DPOL.12.VA with associated COC form number DCOC.CER.12.VA.

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UHC Dental Market Solutions

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