

**UnitedHealthcare**  
**Voluntary Options PPO/covered dental services**

dental plan  
**Custom P4429**

		NON-ORTHODONTICS		
		NETWORK	NON-NETWORK	
Individual Plan Year Deductible	\$50	\$50		
Family Plan Year Deductible	\$150	\$150		
Maximum (the sum of all Network and Non-Network benefits will not exceed plan year maximum)	\$750 per person per Plan Year	\$750 per person per Plan Year		
New enrollee's waiting period:				
<b>Plan year deductible applies to preventive and diagnostic services</b>			No (In Network)	No (Out Network)
COVERED SERVICES*	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES	
<b>DIAGNOSTIC SERVICES</b>				
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.	
Radiographs	100%	100%	Bite-wing: Limited to 1 series of films per Plan Year. Complete/Panorex: Limited to 1 time per consecutive 36 months.	
Lab and Other Diagnostic Tests	100%	100%		
<b>PREVENTIVE SERVICES</b>				
Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.	
Fluoride Treatment (Preventive)	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, limited to 1 per consecutive 60 months.	
<b>BASIC SERVICES</b>				
Restorations (Amalgam or Anterior Composite)*	80%	60%	Multiple restorations on one surface will be treated as a single filling.	
Emergency Treatment / General Services	80%	60%	Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: When clinically necessary.	
Simple Extractions	80%	60%	Limited to 1 time per tooth per lifetime.	
Oral Surgery (includes surgical extractions)	80%	60%		
Periodontics	80%	60%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. 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, exclusive of gross debridement.	
Endodontics	80%	60%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.	
<b>MAJOR SERVICES</b>				
Inlays/Onlays/Crowns*	50%	40%	Limited to 1 time per tooth per consecutive 60 months.	
Dentures and other Removable Prosthetics	50%	40%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	
Fixed Partial Dentures (Bridges)*	50%	40%	Once per tooth per consecutive 60 months.	

\* 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.

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

## General Limitations

PERIODIC ORAL EVALUATION 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 Paronex Radiograph if taken for diagnosis of molars, Cysts or neoplasms

BITEWING RADIOGRAPHS Limited to 1 series of films per PlanYear

EXTRAORAL RADIOGRAPHS Limited to 2 films per PlanYear

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

FLUORIDE TREATMENTS Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

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. Limited to 1 per consecutive 60 months. Benefit includes all adjustment within 6 months of installation

RESTORATIONS Multiple restorations on 1 surface will be treated as a single filling.

PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.

INLAYS AND ONLAYS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

CROWNS Limited to 1 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.

ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

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.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 time per consecutive 6 months.

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than exam and radiographs, were performed on the same tooth during the visit.

OCCUSAL GUARDS Limited to 1 guard every consecutive 36 months and only if prescribe to control habitual grinding.

FULL MOUTH DEBRIDMENT Limited to 1 time every consecutive 36 months.

GENERAL ANESTHESIA Covered only when clinically necessary.

OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 per quadrant or site per consecutive 36 months per surgical area

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.

## 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 becoming enrolled under the policy.
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. Foreign services are not covered 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 covered under the policy for 12 continuous months.
15. 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.
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, implants-supported abutments and prostheses. (Not applicable for plans with implants)
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. 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.
22. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue
23. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint. (Not Applicable for Plans with TMJ).
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia
25. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
26. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
27. Occlusal guard used as safety items or to affect performance primarily in sports-related activities
28. 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.
29. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

## NON-DISCRIMINATION NOTICE

UnitedHealthcare StudentResources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator  
United HealthCare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UTAH 84130  
[UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free **1-800-368-1019, 800-537-7697** (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

**LANGUAGE ASSISTANCE PROGRAM**

**We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.**

**English**

Language assistance services are available to you free of charge. Please call 1-866-260-2723.

**Albanian**

Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

**Amharic**

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**Arabic**

تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

**Armenian**

Ձեզ մատչելի են անվճար լեզվալսյան օգնությունները: Խնդրում ենք զանգահարել 1-866-260-2723 համարով:

**Bantu- Kirundi**

Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

**Bisayan- Visayan (Cebuano)**

Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

**Bengali- Bangala**

ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দয়া করে 1-866-260-2723-তে কল করুন।

**Burmese**

ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

**Cambodian- Mon-Khmer**

សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមមុនស្តីពីទៅលេខ 1-866-260-2723។

**Cherokee**

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**Chinese**

您可以免費獲得語言援助服務。請致電 1-866-260-2723。

**Choctaw**

Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla ho chi apela hinla. I paya 1-866-260-2723.

**Cushite- Oromo**

Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

**Dutch**

Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

**French**

Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

**French Creole- Haitian Creole**

Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

**German**

Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

**Greek**

Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Κωλέστε το 1-866-260-2723.

**Gujarati**

ભાષા સહાય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કોલ કરો.

**Hawaiian**

Kōkua manuahi ma kāu ‘ōlelo i loa‘a ‘ia. E kelepona i ka helu 1-866-260-2723.

**Hindi**

आप के लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

**Hmong**

Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

**Ibo**

Enyemaka na-ahazi asusu, bu n'efu, diri gi. Kpoo 1-866-260-2723.

**Ilocano**

Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

**Indonesian**

Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

**Italian**

Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

**Japanese**

無料の言語支援サービスをご利用いただけます。1-866-260-2723 までお電話ください。

**Karen**

ကျိတ်တံခမၤအတီၢ်န့ၢ်အီၤသ့ၣ်လၢတၢ်လိၣ်ဟ့ၣ်အပူၤဘၣ်(ခီၣ်)န့ၣ်လီၤ. ဝံသးစူၤဆဲးကျိးဘၣ် 1-866-260-2723တကျိၤ.

**Korean**

언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

**Kru- Bassa**

Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yon. Sebel i nsinga ini 1-866-260-2723.

**Kurdish Sorani**

خزمهتگانی یارمعتیی زمانی بهخۆرایی بۆ تۆ دابین دهکرتین. تکایه تلهفۆن بکه بۆ ژمارهی 1-866-260-2723.

**Laotian**

ມີບໍລິການທາງດ້ານພາສາບໍ່ແຈ້ງໃຫ້ແກ່ທ່ານ. ກະລຸນາໃຫ້ຫາເບີ 1-866-260-2723.

