

# UnitedHealthcare Dental® In Network Only PPO (INO)/covered dental services

dental plan  
PIN02

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
<b>Annual Deductible</b>	\$0	\$0	\$0	\$0
<b>Maximum</b> (the sum of all Network and Non-Network benefits will not exceed annual maximum)	\$1,500 per person per calendar year	\$1,500 per person per calendar year	\$1,000 per person per lifetime	\$1,000 per person per lifetime

	NETWORK	NON-NETWORK
<b>For new enrollees, there will be a waiting period of:</b>	N/A	N/A

COVERED SERVICES	PROCEDURE CODE	NETWORK ENROLLEE PAYS*	NON-NETWORK ENROLLEE PAYS**	BENEFIT GUIDELINES
<b>PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES</b>				
Periodic Oral Examinations	120	\$0	100%	Up to 2 per year.
Bite-Wing X-rays	274	\$0	100%	One series of films per year.
Complete Series or Panorex X-rays	210/330	\$0	100%	One time per 36 months.
Dental Prophylaxis (Cleanings)	1110	\$0	100%	Up to 2 per year.
Fluoride Treatments	1201	\$0	100%	For covered persons under the age of 16 years, up to 2 per year.
Sealants	1351	\$0	100%	For covered persons under the age of 16 years, once per first or second permanent molar every 5 years.
<b>BASIC DENTAL SERVICES (Minor Restorative, Endodontics, Periodontics and Oral Surgery)</b>				
Amalgam Restorations (Fillings)	2150	\$40	100%	One restoration allowed per surface every 3 years.
Composite Resin Restorations (Fillings)	2331	\$47	100%	One restoration allowed per surface every 3 years.
Space Maintainers	1515	\$100	100%	For covered persons under the age of 16 years, once per lifetime.
Root Canal Treatment	3330	\$235	100%	Once per site per lifetime.
Root Planing	4341	\$70	100%	Once every 24 months per quadrant.
Periodontal Surgery	4260	\$339	100%	Once every 36 months per site.
Surgical Extraction including Impacted Wisdom Teeth	7240	\$145	100%	
General Anesthesia	9220	\$115	100%	When clinically necessary.
Palliative Treatment (Relief of Pain)	9110	\$35	\$35	Covered as a separate benefit only if no other services except exam and X-rays were performed during the visit.
<b>MAJOR DENTAL SERVICES</b>				
Crowns	2750	\$380	100%	Once every 5 years.
Fixed Bridges	6240	\$380	100%	Once every 5 years. (Alternate benefits for a partial denture may be applied).
Full Dentures	5110	\$440	100%	Once every 5 years. No allowances for over-dentures or customized dentures.
Inlays and Onlays	2520	\$310	100%	Once every 5 years.
Partial Dentures	5214	\$440	100%	Once every 5 years; no allowance for precision or semi precision attachments.
Recement Bridges, Crowns, Inlays	2920	\$25	100%	Once every 6 months per restoration.
Relining Dentures	5730	\$100	100%	Once every year after the 6 month period following initial insertion.
Repairs to Full Dentures, Partial Dentures, Bridges	5510	\$65	100%	For repairs or adjustments done after 12 months following the initial insertion.
<b>ORTHODONTIC SERVICES</b>				
Orthodontics – Adult & Child	8080	50%	50%	Preauthorization required.

\*The network enrollee copay will be the lesser of the copay shown above and the discounted fee negotiated with the provider.

\*\*The non-network orthodontic percentage of benefits is based on the usual and customary rates prevailing in the geographic area in which the expenses are incurred.

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 upon which the plan benefit is based, your actual out-of-pocket expense will be: the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the fee for the service actually rendered and the fee for the service upon which the plan benefit is based.

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 In-Network Only PPO (INO) 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.

# UnitedHealthcare Dental/exclusions and limitations

## GENERAL LIMITATIONS

**ORAL EXAMINATIONS** Covered as a separate benefit only if no other service was done during the visit other than X-rays. Limited to 2 times per calendar year.

**COMPLETE SERIES OR PANOREX RADIOGRAPHS** Limited to one time per 36 months.

**BITEWING RADIOGRAPHS** Limited to 1 series of films per calendar year.

**EXTRAORAL RADIOGRAPHS** Limited to 2 films per calendar year.

**DENTAL PROPHYLAXIS** Limited to 2 times per calendar year.

**DIAGNOSTIC CASTS** Limited to one time per 24 months.

**FLUORIDE TREATMENTS** Limited to Covered Persons under the age of 16 years, and limited to 2 times per calendar year. Treatment should be done in conjunction with dental prophylaxis.

**SEALANTS** Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every 5 years.

**SPACE MAINTAINERS** Limited to Covered Persons under the age of 16 years, once per lifetime. Benefit includes all adjustment within 6 months of installation.

**AMALGAM RESTORATIONS** Multiple restorations on one surface will be treated as a single filling.

**PIN RETENTION** Limited to 2 pins per tooth; not covered in addition to Cast Restoration.

**GOLD INLAYS AND ONLAYS** Limited to one time per 5 calendar years. Covered only when silver fillings cannot restore the tooth.

**CROWNS** Limited to one time per 5 calendar years. 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 done during the visit.

**SCALING AND ROOT PLANING** Limited to 1 time per quadrant per 24 months.

**PERIODONTAL MAINTENANCE** Limited to 2 times within the first 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.

**FULL DENTURES** No additional allowances for over-dentures or customized dentures.

**PARTIAL DENTURES** No additional allowances for precision or semi precision attachments.

**RELINING DENTURES** Limited to relining done more than 6 months after the initial insertions. Limited to 1 time per calendar year.

**REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES** Limited to repairs or adjustments done within 12 months after the initial insertion.

**PALLIATIVE TREATMENT** Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.

**OCCUSAL GUARDS** Limited to one guard every 5 years.

## 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's eligibility with the Plan.
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. Dental Services provided in a foreign country, 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 eligible for 12 continuous months.
15. Full mouth radiograph series in excess of once every 36 months. Panoramic radiographs in excess of once every 36 months, except when taken for diagnosis of third molars, cysts, or neoplasms.
16. Hard tissue periodontal surgery and soft tissue periodontal surgery per surgical area in excess of once in any 36 month period. This includes gingivectomy, gingivoplasty, gingival curettage (with or without a flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.
17. Osseous grafts, with or without resorbable or non-resorbable GTR membrane placement in excess of once every 36 months per quadrant or surgical site.
18. Root planing and scaling (ADA Code 4341) in excess of once every 24 months per quadrant.
19. Full mouth debridement (ADA Code 4355) in excess of once every 36 months.
20. Replacement of complete or partial dentures, fixed bridgework, or crowns previously submitted for payment under the Plan within sixty (60) months of initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
21. Replacement of complete or partial dentures, crowns, or fixed bridgework 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.
22. Denture relines for complete or partial conventional dentures for the 6 month period following the insertion of a prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures for the first six 6 months. After the six month waiting period, relines are covered not more than once every 12 months.
23. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
24. 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.
25. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
26. Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
27. Placement of fixed bridgework solely for the purpose of achieving periodontal stability.
28. Billing for incision and drainage (ADA Code 7510) if the involved abscessed tooth is removed on the same date of service.
29. Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision.
30. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
31. 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.
32. Acupuncture; acupressure and other forms of alternative treatment.
33. General Anesthesia, except if required for patients under 6 years of age or patients with behavioral problems or physical disabilities.
34. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
35. Occlusal guards except if prescribed to control of habitual grinding, including those specifically used as safety items or to affect performance primarily in sports-related activities.
36. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.