

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

"High Option" - P3812

	Non-Orthodontics		Orthodontics	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Individual Annual Deductible</b>	\$50	\$100	NOT COVERED	NOT COVERED
<b>Family Annual Deductible</b>	\$150	\$300	NOT COVERED	NOT COVERED
<b>Maximum (combined for both In-Network and Out-of-Network services)</b>	\$ 1500 per person per calendar year	\$ 500 per person per calendar year	NOT COVERED	NOT COVERED

	In-Network	Out-Of-Network
<b>Annual deductible applies to preventive and diagnostic services</b>	No	No
<b>Annual deductible applies to orthodontic services</b>	NOT COVERED	NOT COVERED
<b>This plan has no waiting periods.</b>		

Covered Services	In-Network Plan Pays*	Out-of-Network Plan Pays**	Benefit Guidelines
<b>Preventive and Diagnostic Dental Services</b>			
Periodic Oral Examinations	100%	50%	Covered as a separate benefit only if no other service was done during the visit other than X-rays. Limited to once every 6 months.
Bitewing X-rays	100%	50%	Limited to 1 series of films per calendar year.
Complete Series or Panorex X-rays	100%	50%	Limited to one time per 36 months.
Dental Prophylaxis (Cleanings)	100%	50%	Limited to once every 6 months.
Fluoride Treatments	100%	50%	Limited to Covered Persons under the age of 16 years, and limited to once per six month period. Treatment should be done in conjunction with dental prophylaxis.
Sealants	100%	50%	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every 3 years.
<b>Basic Dental Services</b>			
Amalgam Restorations	100%	10%	Multiple restorations on one surface will be treated as a single filling.
Composite Resin Restorations (Fillings)	100%	10%	Multiple restorations on one surface will be treated as a single filling.
Space Maintainers	100%	10%	Limited to Covered Persons under the age of 16

			years, once per lifetime. Benefit includes all adjustment within 6 months of installation.
Root Canal Treatment	100%	10%	
Root Planing	100%	10%	Limited to 1 time per quadrant per 24 months.
Periodontal Surgery	100%	10%	Once in any 36 month period.
Simple Extraction	100%	10%	
Surgical Extraction including Impacted Wisdom Teeth	100%	10%	
General Anesthesia	100%	10%	When clinically necessary
Palliative Treatment (Relief of Pain)	100%	10%	Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.

**Major Dental Services**

Crowns	50%	10%	Limited to one time per tooth every 5 calendar years. Covered only when a filling cannot restore the tooth.
Fixed Bridges	50%	10%	Limited to one time per tooth every 5 calendar years. Covered only when a filling cannot restore the tooth.(alternate benefits for a partial denture may be applied
Full Dentures	50%	10%	Once every 60 months. No additional allowances for over-dentures or customized dentures.
Inlays and Onlays	50%	10%	Limited to one time per 5 calendar years. Covered only when silver fillings cannot restore the tooth.
Partial Dentures	50%	10%	Once every 60 months. No additional allowances for precision or semi precision attachments.
Recement Bridges, Crowns and Inlays	50%	10%	Once every 6 months per restoration
Relining Dentures	50%	10%	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	50%	10%	Limited to repairs or adjustments done within 12 months after the initial insertion.

*\*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.