UnitedHealthcare®
National Options PPO 20 Network/covered dental services

dental plan
P0206 /MAC

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Annual Maximum Benefit *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	$1500 per person per Calendar Year	$1500 per person per Calendar Year	$1500 per person per Lifetime	$1500 per person per Lifetime
Annual Deductible Applies to Preventive and Diagnostic Services	No			
Annual Deductible Applies to Orthodontic Services	No			
Waiting Period	No waiting period			
Orthodontic Eligibility Requirement	Child Only Up to Age 19			

COVERED SERVICES*	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs - Bitewing	100%	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Radiographs - Intraoral/Extraoral	100%	100%	Limited to 2 films per calendar year.
Lab and Other Diagnostic Tests	100%	100%	
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.
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, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
Restorations (Amalgam or Anterior Composite)*	80%	80%	Multiple restorations on one surface will be treated as a single filling.
General Services - Emergency Treatment	80%	80%	Covered as a separate benefit only if no other service was done during the visit other than X-rays.
General Services - Occlusal Guards	80%	80%	Limited to 1 guard every consecutive 36 months.
General Services - Anesthesia	80%	80%	When clinically necessary.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
Oral Surgery - Brush Biopsy	80%	80%	
Oral Surgery - Surgical Extractions	80%	80%	
Oral Surgery - Partial/Bony	80%	80%	
Oral Surgery - Other	80%	80%	
Endodontics - Pulpotomy	80%	80%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
Endodontics - Other	80%	80%	
Periodontal Maintenance	80%	80%	Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
Periodontics - Non Surgical	80%	80%	Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months.
Periodontics - Surgical	80%	80%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
Periodontics - Osseous Surgery	80%	80%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
MAJOR DENTAL SERVICES			
Inlays/Onlays/Crowns*	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	50%	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%	50%	Limited to 1 time per tooth per consecutive 60 months.
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	

* 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 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 fee 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.

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 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 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: UnitedHealthcare Insurance Company, Hartford, Connecticut; UnitedHealthcare Insurance Company of New York, Hauppage, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York; or United HealthCare Services, Inc.

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Welcome

to your PPO dental plan

We're happy that you have decided to become a UnitedHealthcare dental member. We will do everything we can to make your experience a positive one.

Take a few minutes to review this information, and remember that we're here to help if you have questions. Simply call Customer Care at the number on your ID card.

How does my plan work?

With this plan, you are free to see any dentist across the country, but we encourage you to choose a dentist who is part of our network. Network dentists agree to discount their services for our members. And choosing a network dentist is easy thanks to our large national network.

If you need to see a specialist, we encourage you to work with your primary care dentist who understands your needs. However, you are not required to get a referral.

There are two ways to find a network dentist. Visit **myuhc.com** and use the Find a Dentist tool or give us a call at the number on your ID card.

What is covered by my plan?

Preventive care—Your plan covers preventive services, such as routine exams and cleanings, at little or no cost to you as long as you see a dentist who is part of our network. If you receive your preventive services from a dentist who is not part of the network, you will likely be billed for the difference between what the plan pays and what your dentist charges for the service.

Your plan covers two preventive visits in 12 consecutive months.

Extra services if you're pregnant

If you are pregnant, your plan covers extra visits for cleanings and gum treatments as recommended by your dentist. Take advantage of this benefit because during pregnancy women can have increased levels of bacteria in the mouth which can lead to tooth decay. Ask your dentist to submit a paper claim to the claims address on your ID card, including the name of your obstetrician and your pregnancy due date, and we'll take care of the rest.

Other types of care—Your dental plan also covers fillings and may cover procedures such as crowns and bridges. Some plans only cover silver fillings for back teeth. If you choose white fillings, you may need to pay the difference.

Seven things to know:

1. You can see any dentist in or outside of our large national network.
2. You can save money if you see a dentist who is part of the network.
3. You don't need a referral to see a specialist.
4. Preventive services are covered at little or no cost to you.
5. Getting an estimate for dental services that may cost more than $500 is a good idea.
6. There's a website just for you–**myuhc.com**.
7. Call us at the number on your ID card anytime you have a question.

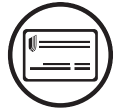
Online tools you'll find helpful:

Find a Dentist: The easiest way to find a network dentist is to log in to **myuhc.com**. That way, you'll only see your plan's network.

If you decide not to log in, you can still use the online Find a Dentist tool, but you'll have to select your network from a list of networks, which is an added step.

Dental Cost Calculator: This **myuhc.com** tool will help you understand the amount you will need to pay out of pocket.

Your ID card:



- You can print your ID card from **myuhc.com**.
- If you are a new member, you will be issued a card. If you are not, continue to use the one you have.
- Your ID card only lists the name of the person who signed up for the plan, but all of those covered by your plan should use this card.
- Bring your dental ID card with you each time you see the dentist.

Deductibles

For services other than preventive care, you may have to pay a set amount called a deductible before your coverage begins paying for these services.

Sharing the costs

Once any necessary deductible is met, your benefits begin. You and your dental plan will share the costs of the services you receive. The percentage your dental plan pays is called coinsurance.

Annual maximum

Your plan will pay for services up to a set amount, called an annual maximum. It's important to know that preventive services, such as your routine dental checkups, may count toward your annual maximum. Once you meet your annual maximum, you are responsible for all the costs for any additional dental care you may need.

Cosmetic procedures

Also remember that some services, such as teeth whitening, that are done to improve the look of your teeth may not be covered by your plan

Pre-treatment estimate

If you're having a procedure that may cost more than $500, we recommend that you ask your dentist to send us x-rays and notes about your dental condition. We will review the recommended treatment to make sure that the procedure is considered medically necessary. If it is not, the procedure will not be covered. After we review the information, we will give your dentist an estimate of what we will pay for the procedure, so you know how much you will need to pay.

Questions?

If you have questions about your benefits, visit **myuhc.com** or call Customer Care. Thank you again for choosing UnitedHealthcare. You're on your way to a healthy, beautiful smile!

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 UnitedHealthcare Insurance 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 Virginia use policy form number DPOL.06.VA and associated COC form number DCOC.CER.06.VA.

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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 AND ONLAYS** 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.

GENERAL EXCLUSIONS

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 wi 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 t 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 o 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.

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GENERAL EXCLUSIONS

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 th 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.

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Dental

Keep your mouth healthy during pregnancy

When you're pregnant, you're eating for two. You're also brushing for two.

The Prenatal Dental Care program is for pregnant women throughout their pregnancy and three months after baby is born.[1] This is because studies show that dental disease during pregnancy can affect your health and possibly even your baby's. This benefit provides coverage to women during pregnancy and three months after delivery for the following dental services:

- Dental cleanings
- Non-surgical gum treatment
- Gum maintenance (care to keep gums healthy after treatment is complete)

There are no limits on how often these services can be provided during this time. The dentist will decide how often these services are needed.

As part of this program, these services:

- **Are covered at 100%.** There's no cost to you if you see a dentist who is part of our network.[2]
- **Do not count toward your annual maximum.** This annual maximum is the most the dental plan will cover in a given year.
- **Do not count toward your deductible.** The deductible is the amount you must pay before your dental plan starts to pay.

With the Prenatal Dental Care program:

- You don't need a referral to get these services
- A waiting period does not apply to these services. A waiting period is the amount of time you have to wait before you can use your benefits.[3]

You should know:

- If you are pregnant, see your dentist for a checkup. Tell the dentist you're pregnant. Give your doctor's name and your due date.
- Make sure your dentist puts your doctor's name and your due date on the claim form.
- Cleaning, scaling and other services are covered at 100%.

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Make an appointment with your dentist.

Simply make an appointment with your dentist for a checkup and cleaning. Tell the dentist your due date and the name of your doctor or nurse-midwife. Ask that your due date and the name of your doctor be added to the claim form. This way, your visit will be covered by this program.

Customer Care

Questions? Call the Customer Care number on your member ID card.

[1] Prenatal Dental benefit not available in the state of Washington.

[2] If your plan provides coverage for out-of-network care and you receive these services from a non-network provider, you may have additional costs.

[3] Note that some plans include waiting periods, while others do not. Your benefit document outlines the specific requirements for your plan.

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 UnitedHealthcare Insurance 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 and associated COC form number DCOC.CER.06. Plans sold in Virginia use policy form number DPOL.06.VA and associated COC form number DCOC.CER.06.VA.

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Dental

Preventing and treating mouth cancer

Cancer of the mouth is called oral cancer. It strikes more than 37,000 people in the United States each year. It often is not discovered until it is more advanced. As a result, there is less than a 50% survival rate five years after diagnosis.*

Oral cancer can strike anyone, but the leading risk factors include:

- Smoking
- Chewing tobacco
- Drinking alcohol
- Contracting the human papillomavirus (HPV). This is a common sexually transmitted disease

New tests detect cancer sooner.

New screening tools may help to find oral cancer sooner. With light contrast screening, it can be detected and treated earlier. The medical term for light contrast screening is "fluorescence visualization." The test uses light to help your dentist find healthy and unhealthy tissue.

You should know:

- More than 37,000 people in the U.S. are diagnosed with oral cancer each year.[1]
- Risk factors include tobacco and alcohol use.
- New tests help detect oral cancer earlier and are covered by UnitedHealthcare for adult patients.
- Treatment may be more effective when it is started earlier.

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There are two light contrast tests:

- One test passes a light over tissue treated with a special solution. Normal tissue absorbs the light and appears dark. Abnormal tissue appears white.
- Another test shines a blue light into the mouth. This shows the deeper tissue layers where pre-cancer changes often start.

A brush biopsy is often done as a follow-up to light contrast. It may also be done if there is suspicious tissue. A dentist uses a brush to take a tissue sample from the suspicious area. The sample is then sent to a lab. If the results are positive, a biopsy is done.

A biopsy involves removing a tissue sample with a scalpel. Then, it is studied in a lab. The results help determine a final diagnosis and a plan of treatment.

New testing procedures are covered.

These tests are often done in addition to traditional manual screening and are covered by UnitedHealthcare for adult patients. Visit your dentist regularly and use your oral cancer screening benefit. Remember, early detection is important.

Mouth cancer warning signs:

- Red and/or white spots in your mouth or on your lips
- Sores in your mouth or on your lip that don't heal
- Changes to the surface of your mouth or lip tissue
- Bleeding in the mouth
- Loose teeth
- Difficulty swallowing
- Ear pain
- Numbness of the tongue or other mouth parts
- Jaw swelling

[1] The Oral Cancer Foundation, http://oralcancerfoundation.org/facts/index.htm, last modified 2013.

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This product is not available in all states.

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