# UnitedHealthcare Dental Managed Indemnity/covered dental services Custom Option 1 I1502

## NON-ORTHODONTICS

<table>
<thead>
<tr>
<th></th>
<th>Individual Plan Year Deductible</th>
<th>$50</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Family Plan Year Deductible</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td></td>
<td>$1000 per person per Plan Year</td>
</tr>
<tr>
<td>New enrollee’s waiting period:</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Plan year deductible applies to preventive and diagnostic services</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

## COVERED SERVICES

### PLAN PAYS**

<table>
<thead>
<tr>
<th>COVERED SERVICES*</th>
<th>PLAN PAYS**</th>
<th>BENEFIT GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIAGNOSTIC SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic Oral Evaluation</td>
<td>100%</td>
<td>Limited to 2 times per consecutive 12 months.</td>
</tr>
<tr>
<td>Radiographs</td>
<td>100%</td>
<td>Bite-wing: Limited to 1 series of film per Plan Year . Complete/Panorex: Limited to one time per consecutive 36 months.</td>
</tr>
<tr>
<td>Lab and Other Diagnostic Tests</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>PREVENTIVE SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prophylaxis (Cleanings)</td>
<td>100%</td>
<td>Limited to 2 times per consecutive 12 months.</td>
</tr>
<tr>
<td>Fluoride Treatment (Preventive)</td>
<td>100%</td>
<td>Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months. Treatment should be done in conjunction with dental prophylaxis.</td>
</tr>
<tr>
<td>Sealants</td>
<td>100%</td>
<td>Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.</td>
</tr>
<tr>
<td><strong>BASIC SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space Maintainers</td>
<td>80%</td>
<td>For covered Persons under the age of 16 years, limited to 1 per consecutive 60 months.</td>
</tr>
<tr>
<td>Restorations (Amalgams or Composite)</td>
<td>80%</td>
<td>Multiple restorations on one surface will be treated as a single filling.</td>
</tr>
<tr>
<td>General Services (incl. Emergency Treatment)</td>
<td>80%</td>
<td>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.</td>
</tr>
<tr>
<td>Simple Extractions</td>
<td>80%</td>
<td>Limited to 1 time per tooth per lifetime.</td>
</tr>
<tr>
<td>Oral Surgery (includes surgical extractions)</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Periodontics</td>
<td>80%</td>
<td>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</td>
</tr>
<tr>
<td>Endodontics</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td><strong>MAJOR SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inlays/Onlays/Crowns</td>
<td>0%</td>
<td>Limited to 1 time per tooth per consecutive 60 months.</td>
</tr>
<tr>
<td>Dentures and other Removable Prosthetics</td>
<td>0%</td>
<td>Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. Occlusal Guard: Covered only if prescribed to control habitual grinding, and limited to 1 guard every consecutive 36 months.</td>
</tr>
<tr>
<td>Fixed Prosthetics</td>
<td>0%</td>
<td>Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.(alternate benefits for a partial denture may be applied)</td>
</tr>
<tr>
<td>Fixed Partial Dentures (Bridges)</td>
<td>0%</td>
<td>Limited to one time per tooth per consecutive 60 months.</td>
</tr>
</tbody>
</table>

**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 percentage of benefits is based on the usual and customary fees 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 Managed Indemnity Plan is either underwritten or provided by: United HealthCare Insurance Company, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, NewYork, NewYork; NewYork, NewYork, or United HealthCare Services, Inc. 04/08 ©2008-2009 United Healthcare Services, Inc.
General Limitations

PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

COMPLETE SERIES OR PANORAMIC RADIOPHGRAPHS Limited to one time per consecutive 36 months. Exception to this limit will be made for Panoramic Radiograph if taken for diagnosis of molars, Cysts or neoplasms.

BITEWING RADIOPHGRAPHS Limited to 1 series of films per Plan Year.

EXTRORAL RADIOPHGRAPHS Limited to 2 films per Plan Year.

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 6 months. Benefits include 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 crown 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.

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

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 DENTURES Limited to relining/rebaseing 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.

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

FULL MOUTH DEBRIDEMENT 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 relines, habit appliances, and any fixed or removable interceptive orthodontic appliances.

UnitedHealthcare/Dental Exclusions and Limitations

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 Medicare or Medicaid.

9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.

10. Dental Services rendered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for injuries or conditions covered by Medicaid or Medicare.

11. Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.

12. Dental Services rendered under the Policy, but rendered after the date individual Coverage under the Policy terminates.

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.

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.

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

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


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


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

Amharic
录取が Greeks アムハラ語 ب لغة إثيوبيا ما مثلك وابنه اثنين من أ acompaña ما 1-866-260-2723

Arabic
تم توفير خدمات المساعدة باللغة مجانًا. انطلق على الرقم 1-866-260-2723.

Armenian
2kg կենցաղի ին անցած կազմավորված օգտագործվող համարակալներին. ձեռնարկել են զանգավազքի 1-866-260-2723 համարակալով.

Bantu- Kirundi
Unoswa ku bantu serivisi ziatifye ku turimi zo kugafasha. Utegereza wa gahurunagura 1-866-260-2723.

Bisayan- Visayan (Cebuano)
Magamit nimo ang mga serbisyo sa tubang sa lenguawhe nga walyay bayad. Pailhug tawag sa 1-866-260-2723.

Bengali- Bangla
আমি তোমার সাথে আলাপ করতে চর্চায় আমি তোমার সাথে কথা কথায়।

Burmese
ဦးဆောင်သော ပြည်သူပေးထားသော ပြည်သူများအတွက် 1-866-260-2723 ဖြင့် ဖြင့်လည်း

Cambodian- Mon-Khmer
ការផ្តល់ជូនសំណួរជាអ្វីដែលមានអត្ថប្រយោជន៍ 1-866-260-2723 ដេរីអាហá

Cherokee
 Cherokee 1-866-260-2723: 180-260-2723

Chinese
您可以免費獲得語言援助服務。請致電 1-866-260-2723。

Chocotaw
Chaha anumpa ish anumpuli hokmvv tosholi yvt phe pillars hq chi apele huln. I paya 1-866-260-2723.

Cushite- Oromo
Tajaaqiliwven gargaarsa afaamii kinfalttti mulee stff jira.

Dutch
Taalhulpstandaardisten 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

German

Greek
Οι αναπηρίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

Gujarati
ભાષા સહાય સેવાઓ તમારા માટે નિયમિત ઉપલબ્ધ છે. કામ કરીને 1-866-260-2723 પર ક્રમ કરેલ.

Hawaiian
Kūkaʻa marauahi na kaʻoelelo i loa’a ia. E kelepona i ka helu 1-866-260-2723.

Hindi
आप के लिए भाषा सहायता सेवाओं का नियमित उपलब्ध है। कृपया 1-866-260-2723 पर कॉल करें।

Hmong

Ibo

Ilocano
Addaawan bayadana a sersisio para iti language assistance. Panggaassin ti 1-866-260-2723.

Indonesian

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
ကအောက်မှာပို့ပေးနိုင်သော ပြည်သူပေးထားသော ပြည်သူများ 1-866-260-2723 ဖြင့် ဖြင့်လည်း

Korean
언어 지원 서비스는 무료로 이용하실 수 있습니다. 1-866-260-2723 범주 전화관련.

Kru- Bassa
Bot ba hola ni kobol mahop ngai naa wogui wo ba yé ha i nyuuy yog. Sebele i nsinga ini 1-866-260-2723.

Kurdish- Sorani
خەزانەکانی دەیەکە لەژیبەکانی بەشەبێت برویە بۆ توێنان دەگرێن. لەکە نەخۆشەکە بۆ ژمارەی 1-866-260-2723.

Laotian
Muuviar hânh hàng mâu chênh phamplet có gôay: Tampilkan gái 1-866-260-2723.

SR LAP 84 (6-18)