

UnitedHealthcare
Options PPO/covered dental services
 City of Deltona

dental plan
 P4583

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	\$50	\$50	\$0	\$0
Family Annual Deductible	\$150	\$150	\$0	\$0
Maximum (the sum of all Network and Non-Network benefits will not exceed annual maximum)	\$1000 per person per Calendar	\$1000 per person per Calendar	\$1500 per person per Lifetime	\$1500 per person per Lifetime
New enrollee's waiting period:				
Annual deductible applies to preventive and diagnostic services			No	
Annual deductible applies to orthodontic services			No	
Orthodontic eligibility requirement			Adult & Child	
COVERED SERVICES	NETWORK PLAN PAYS*	NON-NETWORK PLAN PAYS**	BENEFIT GUIDELINES	
PREVENTIVE & DIAGNOSTIC				
Oral Evaluations (Diagnostic)	100%	100%	Covered as a separate benefit only if no other service was done during the visit other than X-rays. Limited to 2 times per consecutive 12 months.	
X Rays (Diagnostic)	100%	100%	Bite-wing: Limited to 1 series of film per calendar year. Complete/Panorex: Limited to one time per consecutive 36 months.	
Lab and Other Diagnostic Tests	100%	100%		
Prophylaxis (Preventive)	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. Treatment should be done in conjunction with dental prophylaxis.	
Space Maintainers	100%	100%	Limited to Covered Persons under the age of 16 years, once per lifetime. Benefit includes all adjustment within 6 months of installation.	
BASIC SERVICES				
Sealants	80%	80%	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	
Restorations (Amalgams and Resin Based Only)	80%	80%	Multiple restorations on one surface will be treated as a single filling. Composite: for anterior teeth only.	
General Services (incl. Emergency Treatment)	80%	80%	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%	80%		
Oral Surgery (includes surgical extractions)	80%	80%		
Periodontics	80%	80%	Perio Surgery: Limited to once every consecutive 36 months per surgical area. Root Planning: Limited to one time per quadrant per consecutive 24 months. Perio Maintenance: Limited to 2 times per consecutive 12 months period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.	
Endodontics	80%	80%		
MAJOR SERVICES				
Inlays/Onlays/Crowns	50%	50%	Limited to one time per tooth per consecutive 60 months. Covered only when silver fillings cannot restore the tooth.	
Dentures and other Removable Prosthetics	50%	50%	Once every 60 months. No additional allowances for over-dentures or customized dentures.	
Fixed Prosthetics	50%	50%	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)	
ORTHODONTIC SERVICES				
Orthodontia	50%	50%	Preauthorization required	

This plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future periods.
 *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 usual and customary rates prevailing in the geographic areas 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 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.
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