UnitedHealthcare
Options PPO – AFL-CIO Health & Welfare Plan - Dental Plan

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$0	$0	$0	$0
Family Annual Deductible	$0	$0	$0	$0
Maximum *(the sum of all Network and Non-Network benefits will not exceed annual maximum)*	$3000 per person per Calendar	$3000 per person per Calendar	$3500 per person per Lifetime	$3500 per person per Lifetime
Orthodontic eligibility requirement			Adult & Child	

COVERED SERVICES	NETWORK BENEFITS/ Copayment Amounts*	NON-NETWORK BENEFITS/ Copayment Amounts**	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC			
Oral Evaluations (Diagnostic)	0%	20%	No limit or frequency
X Rays (Diagnostic)	0%	20%	No limit or frequency
Lab and Other Diagnostic Tests	0%	20%	No limit or frequency
Prophylaxis (Preventive)	0%	20%	No limit or frequency
Fluoride Treatment (Preventive)	0%	20%	No limit or frequency
Sealants	0%	20%	No limit or frequency
BASIC SERVICES			
Restorations (Amalgams and Resin Based Only)	20%	20%	No limit or frequency
General Services (incl. Emergency Treatment)	20%	20%	No limit or frequency
Space Maintainers	20%	20%	No limit or frequency
Simple Extractions	20%	20%	No limit or frequency
Oral Surgery (includes surgical extractions)	20%	20%	No limit or frequency
Periodontics	20%	20%	No limit or frequency
Endodontics	20%	20%	No limit or frequency
MAJOR SERVICES			
Inlays/Onlays/Crowns	20%	20%	No limit or frequency
Dentures and other Removable Prosthetics	20%	20%	No limit or frequency
Fixed Prosthetics	20%	20%	No limit or frequency
ORTHODONTIC SERVICES			
Orthodontia	0%	0%	Preauthorization required

*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.