

Dental INO (effective 7/1/2025)



	In the Network	Out of the Network
Deductible*—Before the plan pays, you'll pay all costs up to:		
Employee/Family	\$75/225	\$0
Coinsurance*—Once the deductible is met, the plan pays:		
Diagnostic and preventive services (deductible waived)	100%	0%
Basic dental services:		
Restorations	50%	0%
Simple extractions	50%	0%
Emergency treatment/general services	50%	0%
Endodontics	50%	0%
Periodontics	50%	0%
Oral surgery	50%	0%
Major dental services:		
Crowns and bridges	40%	0%
Dentures	40%	0%
Annual limits—This is the most the plan will pay in the plan year.	\$1,000	\$0

For more information, please read your plan documents. Additional information such as benefit details, plan limitations and exclusions, and the costs of coverage can be found in the Plan Certificate of Coverage

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

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 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 will 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 the 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 of 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.
- 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 situated 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 the date individual Coverage under the Policy terminates.
- 23 Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- 24 Orthodontic Services.
- 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.