2024-2025 Benefits

What is available?

Lab Alley offers 3 medical plans to choose from under UnitedHealthcare as well as one dental plan offering. These benefits are *not* bundled together, and you can elect whichever one you need. The UHC network is called "CHOICE."

When can I join benefits?

All full-time employees are eligible to join our benefits 1st day of the month following 30 days from your date of full-time hire. **Ex**. If you're hired on 10/06/2024, you're eligible to join benefits effective 12/01/2024. If you are hired on 10/01/2024, you may join 11/01/2024.

You may also join our benefits if you have a qualifying life event mid-year within 30 days of event. You're allowed to add or drop dependents (spouse and children) at this time if it is within the 30 window to make a change.

How do I enroll in benefits?

You will receive a welcome email from the EASE portal, and you flow through enrollment after completing portions of your profile with personal information necessary to add you to insurance.

Who may I enroll on benefits with me?

Lab Alley allows full-time employees, spouse, or domestic partner, biological and adopted children to join benefits.

How long do I have for my enrollment election?

It is important that you flow through and complete the EASE Enrollment prior to your effective date on the insurance plan(s).

Per Paycheck Costs starting 4/1/2024 and ending 3/31/2025:

Bi-Weekly Employee Cost: / Level	High E1500i80LX21	Mid E3000i80LX21	Base HE600021
Employee Only	$110.27	$77.45	$48.85
Employee + Spouse	$377.54	$308.61	$248.55
Employee + Children	$328.95	$266.58	$212.24
Employeee + Family	$620.50	$518.75	$430.08

Bi-Weekly Employee Cost: / Level	DENTAL PPO
Employee Only	$15.69
Employee + Spouse	$31.38
Employee + Children	$34.14
Employeee + Family	$52.28

In-Network Benefits	UHC Level Funded	UHC Level Funded	UHC Level Funded
Plan Name	**E1500i80LX21**	**E3000i80LX21**	**HE600021 HSA**
Plan Type	**EPO Copay**	**EPO Copay**	**EPO HDHP - HSA**
Network Name	**Choice**	**Choice**	**Choice**
Metallic Tier	**N/A**	**N/A**	**N/A**
Deductible Type	embedded	embedded	embedded
Ind. Deductible (In/Out)	$1,500 / N/A	$3,000 / N/A	$6,000 / N/A
Fam. Deductible (In/Out)	$3,000 / N/A	$6,000 / N/A	$12,000 / N/A
Coins - Carrier (In)	80%	80%	100%
Ind. OOP Max (In/Out)	$5,000 / N/A	$8,150 / N/A	$6,000 / N/A
Fam OOP Max (In/Out)	$10,000 / N/A	$16,300 / N/A	$12,000 / N/A
PCP CoPay (In)	$0 <19 / $25	$0 <19 / $25	0% after ded
Specialist CoPay (In)	$75	$75	0% after ded
Telehealth (In)	Healthiest You - $0	Healthiest You - $0	Healthiest You - $45
Lab and X-ray (In)	20% after ded	20% after ded	0% after ded
Advanced Imaging (In)	20% after ded	20% after ded	0% after ded
Rx Deductible (Ind/Fam)	N/A	N/A	Included in Medical/ N/A
Rx Drug Card (In)	RX4 ADV - $10 / $35 / $75 / $250	RX4 ADV - $10 / $35 / $75 / $250	CP COINS ADV - 0% after ded / 0% after ded / 0% after ded / 0% after ded
Specialty Med (In)	$10 / $150 / $350 / $500	$10 / $150 / $350 / $500	0% After Calendar year Deductible
Mail Order (In)	2.5x	2.5x	2.5x
Urgent Care (In)	$50	$50	ded+coins
ER (In/Out)	$300 + 20% after ded	$300 + 20% after ded	0% after ded
Inpatient Hosp. (In)	F - 20% after ded / P - 20% after ded	F - 20% after ded / P - 20% after ded	F - 0% after ded / P - 0% after ded
Outpatient Surgery (In)	F - 20% after ded / P - $75	F - 20% after ded / P - $75	F - 0% after ded / P - 0% after ded

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit us at www.myuhc.com or by calling 1-877-797-8812. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-877-797-8812 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500 /Individual Network $3,000 /Family Network Not Covered/Individual Out-of-Network Not Covered/Family Out-of-Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $5,000 individual / $10,000 family; for out-of-network providers Not covered individual / Not covered family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover and out-of-network services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-877-797-8812 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

* For more information about limitations and exceptions, see the plan or policy document at www.myuhc.com.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit Deductible does not apply.	Not covered	Under age 19 - Network visits are covered at No Charge. Out-of-network providers are not covered.
	Specialist visit	$75 copay/visit Deductible does not apply.	Not covered	Out-of-network providers are not covered.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Physician: 20% coinsurance Facility: 20 coinsurance	Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. Sleep studies require a Prior Authorization or benefits could be reduced by 50% of the total cost of the service.
	Imaging (CT/PET scans, MRIs)	Physician: 20 coinsurance Facility: 20 coinsurance	Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myuhc.com	Tier 1 drugs	$10 retail copay, deductible does not apply. $25 mail-order copay, deductible does not apply. $ 10 specialty copay, deductible does not apply.	Not covered	Covers up to a 90-day supply for retail and mail order pharmacies. One retail copay applies per 30-day retail prescription. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Certain drugs may have a prior authorization requirement. Out-of-network pharmacies are not covered.
	Tier 2 drugs	$35 retail copay, deductible does not apply. $88 mail-order copay, deductible does not apply. $ 150specialty copay, deductible does not apply.	Not covered	
	Tier 3 drugs	$75 retail copay, deductible does not apply. $188 mail-order copay, deductible does not apply. $ 350specialty copay, deductible does not apply.	Not covered	
	Tier 4 drugs	$250 retail copay, deductible does not apply. $625 mail-order copay, deductible does not apply. $ 500specialty copay, deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20 coinsurance	Not covered	Out-of-network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	Physician: $75 copay/visit Deductible does not apply. Surgeon: 20 coinsurance	Physician: Not covered Surgeon: Not covered	
If you need immediate medical attention	Emergency room services	ER Physician: 20 coinsurance Facility: $300 copay/visit and 20 coinsurance	ER Physician: 20 coinsurance* Facility: $300 copay/visit and 20 coinsurance*	*Out-of-network emergency services are covered at the Network benefit level.
	Emergency medical transportation	20 coinsurance	20 coinsurance*	

* For more information about limitations and exceptions, see the plan or policy document at www.myuhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	Urgent Care Physician: $50 copay/visit Deductible does not apply. Facility: $50 copay/visit Deductible does not apply.	Urgent Care Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. One copay is applied between the physician charge and the facility charge for urgent care visits. Lab, x-rays or diagnostic testing are not included in the urgent care copay and are subject to the applicable benefit for these services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20 coinsurance	Not covered	Out-of-network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	Physician: 20 coinsurance Surgeon: 20 coinsurance	Physician: Not covered Surgeon: Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician: $75 copay/visit Deductible does not apply. Facility: 20 coinsurance for other outpatient services	Physician: Not covered Facility: Not covered	None
	Inpatient services	Physician: 20 coinsurance Facility: 20 coinsurance	Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. Prior Authorization is required for inpatient services. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	Primary Care Visit: $25 copay/visit Deductible does not apply. Specialist Visit: $75 copay/visit Deductible does not apply.	Not covered	Out-of-network providers are not covered. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20 coinsurance	Not covered	elsewhere in the SBC (i.e. ultrasound). Prior Authorization is required for inpatient services. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Childbirth/delivery facility services	20 coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20 coinsurance	Not covered	30 visits/year. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service. Out-of-network providers are not covered.
	Rehabilitation services	20 coinsurance	Not covered	30 combined visits/year for rehabilitation and habilitation services. Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, and cognitive rehabilitation therapy.
	Habilitation services	20 coinsurance	Not covered	
	Skilled nursing care	20 coinsurance	Not covered	60 visits/year. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Durable medical equipment	20 coinsurance	Not covered	Out-of-network providers are not covered. Prior Authorization is required if greater than $1000. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Hospice services	20 coinsurance	Not covered	Out-of-network providers are not

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan documents for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Out-of-network pharmacies
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care, and
- Weight-loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Hearing aids

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. Other options to continue coverage are available to you too, including individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: UnitedHealthcare at 1-877-797-8812, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**.

* For more information about limitations and exceptions, see the plan or policy document at www.myuhc.com.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-877-797-8812.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-797-8812.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-877-797-8812.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-797-8812.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $2
- **Specialist copayment** $75
- **Hospital (facility) coinsurance** 20
- **Other coinsurance** 20

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,470

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $2
- **Specialist copayment** $75
- **Hospital (facility) coinsurance** 20
- **Other coinsurance** 20

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,400

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $2
- **Specialist copayment** $75
- **Hospital (facility) coinsurance** 20
- **Other coinsurance** 20

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,100

The plan would be responsible for the other costs of these EXAMPLE covered services.

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This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit us at www.myuhc.com or by calling 1-877-797-8812. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-877-797-8812 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2 /Individual Network $3,000 /Family Network Not Covered/Individual Out-of-Network Not Covered/Family Out-of-Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $5 individual / $10,000 family; for out-of-network providers Not covered individual / Not covered family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover and out-of-network services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-877-797-8812 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

* For more information about limitations and exceptions, see the plan or policy document at www.myuhc.com.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit Deductible does not apply.	Not covered	Under age 19 - Network visits are covered at No Charge. Out-of-network providers are not covered.
	Specialist visit	$75 copay/visit Deductible does not apply.	Not covered	Out-of-network providers are not covered.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Physician: 20 coinsurance Facility: 20 coinsurance	Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. Sleep studies require a Prior Authorization or benefits could be reduced by 50% of the total cost of the service.
	Imaging (CT/PET scans, MRIs)	Physician: 20 coinsurance Facility: 20 coinsurance	Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myuhc.com	Tier 1 drugs	$10 retail copay, deductible does not apply. $ 25 mail-order copay, deductible does not apply. $ 10 specialty copay, deductible does not apply.	Not covered	Covers up to a 90-day supply for retail and mail order pharmacies. One retail copay applies per 30-day retail prescription. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Certain drugs may have a prior authorization requirement. Out-of-network pharmacies are not covered.
	Tier 2 drugs	$35 retail copay, deductible does not apply. $ 88 mail-order copay, deductible does not apply. $ 150specialty copay, deductible does not apply.	Not covered	
	Tier 3 drugs	$75 retail copay, deductible does not apply. $ 18£mail-order copay, deductible does not apply. $ 350specialty copay, deductible does not apply.	Not covered	
	Tier 4 drugs	$250 retail copay, deductible does not apply. $625 mail-order copay, deductible does not apply. $ 500specialty copay, deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20 coinsurance	Not covered	Out-of-network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	Physician: $75 copay/visit Deductible does not apply. Surgeon: 20 coinsurance	Physician: Not covered Surgeon: Not covered	
If you need immediate medical attention	Emergency room services	ER Physician: 20 coinsurance Facility: $300 copay/visit and 20 coinsurance	ER Physician: 20 coinsurance* Facility: $300 copay/visit and 20 coinsurance*	*Out-of-network emergency services are covered at the Network benefit level.
	Emergency medical transportation	20 coinsurance	20 coinsurance*	

* For more information about limitations and exceptions, see the plan or policy document at www.myuhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	Urgent Care Physician: $50 copay/visit Deductible does not apply. Facility: $50 copay/visit Deductible does not apply.	Urgent Care Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. One copay is applied between the physician charge and the facility charge for urgent care visits. Lab, x-rays or diagnostic testing are not included in the urgent care copay and are subject to the applicable benefit for these services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20 coinsurance	Not covered	Out-of-network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	Physician: 20 coinsurance Surgeon: 20 coinsurance	Physician: Not covered Surgeon: Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician: $75 copay/visit Deductible does not apply. Facility: 20 coinsurance for other outpatient services	Physician: Not covered Facility: Not covered	None
	Inpatient services	Physician: 20 coinsurance Facility: 20 coinsurance	Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. Prior Authorization is required for inpatient services. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	Primary Care Visit: $25 copay/visit Deductible does not apply. Specialist Visit: $75 copay/visit Deductible does not apply.	Not covered	Out-of-network providers are not covered. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20 coinsurance	Not covered	elsewhere in the SBC (i.e. ultrasound). Prior Authorization is required for inpatient services. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Childbirth/delivery facility services	20 coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20 coinsurance	Not covered	30 visits/year. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service. Out-of-network providers are not covered.
	Rehabilitation services	20 coinsurance	Not covered	30 combined visits/year for rehabilitation and habilitation services. Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, and cognitive rehabilitation therapy.
	Habilitation services	20 coinsurance	Not covered	
	Skilled nursing care	20 coinsurance	Not covered	60 visits/year. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Durable medical equipment	20 coinsurance	Not covered	Out-of-network providers are not covered. Prior Authorization is required if greater than $1000. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Hospice services	20 coinsurance	Not covered	Out-of-network providers are not

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan documents for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Out-of-network pharmacies
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care, and
- Weight-loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Hearing aids

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. Other options to continue coverage are available to you too, including individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: UnitedHealthcare at 1-877-797-8812, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**.

* For more information about limitations and exceptions, see the plan or policy document at www.myuhc.com.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-877-797-8812.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-797-8812.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-877-797-8812.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-797-8812.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $2
- **Specialist copayment** $75
- **Hospital (facility) coinsurance** 20
- **Other coinsurance** 20

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2
Copayments	$10
Coinsurance	$2
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $2
- **Specialist copayment** $75
- **Hospital (facility) coinsurance** 20
- **Other coinsurance** 20

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $2
- **Specialist copayment** $75
- **Hospital (facility) coinsurance** 20
- **Other coinsurance** 20

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit us at www.myuhc.com or by calling 1-877-797-8812. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-877-797-8812 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2 /Individual Network $3,000 /Family Network Not Covered/Individual Out-of-Network Not Covered /Family Out-of-Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $5 individual / $10,000 family; or out-of-network providers Not covered / individual Not covered / family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, and out-of-network services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-877-797-8812 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

* For more information about limitations and exceptions, see the plan or policy document at www.myuhc.com.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20 coinsurance	Not covered	Out-of-Network providers are not covered.
	Specialist visit	20 coinsurance	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Physician: 20 coinsurance Facility: 20 coinsurance	Physician: Not covered Facility: Not covered	Out-of-network providers are not covered. Sleep studies require a Prior Authorization or benefits could be reduced by 50% of the total cost of the service.
	Imaging (CT/PET scans, MRIs)	Physician: 20 coinsurance Facility: 20 coinsurance	Not covered	Out-of-network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myuhc.com	Tier 1 drugs	20 coinsurance	Not covered	Out-of-network pharmacies are not covered. Covers up to a 90-day supply for retail and mail order pharmacies. One retail copay applies per 30-day retail prescription. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference
	Tier 2 drugs	20 coinsurance	Not covered	
	Tier 3 drugs	20 coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Tier 4 drugs	20 coinsurance	Not covered	between drugs in addition to any applicable copay and/or coinsurance may be applied. Certain drugs may have a prior authorization requirement.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20 coinsurance	Not covered	Out-of-network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	Physician: 20 coinsurance Surgeon: 20 coinsurance	Not covered	
If you need immediate medical attention	Emergency room services	ER Physician: 20 coinsurance Facility: 20 coinsurance	ER Physician: 20 coinsurance* Facility: 20 coinsurance*	*Out-of-network emergency services are covered at the Network benefit level.
	Emergency medical transportation	20 coinsurance	20 coinsurance*	
	Urgent care	Urgent Care Physician: 20 coinsurance Facility: 20 coinsurance	Urgent Care Physician: Not covered Facility: Not covered	Out-of-Network providers are not covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	20 coinsurance	Not covered	Out-of-Network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	Physician: 20 coinsurance Surgeon: 20 coinsurance	Physician: Not covered Surgeon: Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician: 20 coinsurance Facility: 20 coinsurance/ other outpatient services	Physician: Not covered Facility: Not covered	Out-of-Network providers are not covered. Prior Authorization is required for inpatient services. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Inpatient services	Physician: 20 coinsurance Facility: 20 coinsurance	Physician: Not covered Facility: Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	20 coinsurance	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests. and services described elsewhere in the SBC (i.e. ultrasound). Out-of-network providers are not covered. Prior Authorization is required for inpatient services. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Childbirth/delivery professional services	20 coinsurance	Not covered	
	Childbirth/delivery facility services	20 coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20 coinsurance	Not covered	30 visits/year. Out-of-network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Rehabilitation services	20 coinsurance	Not covered	30 combined visits/year for rehabilitation and habilitation services. Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, and cognitive rehabilitation therapy.
	Habilitation services	20 coinsurance	Not covered	
	Skilled nursing care	20 coinsurance	Not covered	60 visits/year. Out-of-network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				50% of the total cost of the service.
	Durable medical equipment	20 coinsurance	Not covered	Out-of-network providers are not covered. Prior Authorization is required if greater than $1000. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Hospice services	20 coinsurance	Not covered	Out-of-network providers are not covered. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan documents for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
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- Out-of-network pharmacies
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- Routine eye care (adult)
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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-797-8812.

———————————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*———————————

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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $2
- **Specialist coinsurance** 20
- **Hospital (facility) coinsurance** 20
- **Other coinsurance** 20

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2
Copayments	$10
Coinsurance	$2
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $2
- **Specialist coinsurance** 20
- **Hospital (facility) coinsurance** 20
- **Other coinsurance** 20

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $2
- **Specialist coinsurance** 20
- **Hospital (facility) coinsurance** 20
- **Other coinsurance** 20

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2

The plan would be responsible for the other costs of these EXAMPLE covered services.

UnitedHealthcare®

dental plan

Consumer MaxMultiplier Voluntary Options PPO 30/covered dental services

P3365 /U90

	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50
Family Annual Deductible	$150	$150
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.)*	$1000 per person per calendar year	$1000 per person per calendar year
Annual Deductible Applies to Preventive and Diagnostic Services	No	
Waiting Period	12 months for major services	

COVERED SERVICES**	NETWORK PLAN PAYS***	NON-NETWORK PLAN PAYS****	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs	100%	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
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 *(including Emergency Treatment)*	80%	80%	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. Occlusal Guard: Limited to 1 guard every consecutive 36 months.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
MAJOR DENTAL SERVICES			
Oral Surgery *(includes surgical extractions)*	50%	50%	
Periodontics	50%	50%	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.
Endodontics	50%	50%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
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.

* This plan includes a maximum benefit award program. Some of the unused portion of your annual maximum benefit may be available in future benefit periods.

** 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 schedule of usual and customary fees in the geographic area in which the expenses are incurred.

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® Voluntary 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.

UnitedHealthcare/dental exclusions and limitations

Dental Services described in this section are covered when such services are:

A. Necessary;

B. Proviced 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

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

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.

BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar 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.

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.

SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

RESTORATIONS Multiple restorations on one 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 time 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.

ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

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

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 AND REBASING DENTURES Limited to relining/rebasing 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 per consecutive 6 months.

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.

OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed 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 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 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. 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 Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the Policy.
10. 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.
11. 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.
12. Foreign Services are not covered unless required as an Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been covered under the policy 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 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. Placement of dental implants, implant-supported abutments and prostheses
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 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.
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 guards 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.