Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: UnitedHealthcare Insurance Company
Plan Name: D125H
Policy Type: DHMO/Managed Care
Insurer Phone #: 1-800-445-9090
Effective Date: 7/1/2024
Insurer Website: www.myuhc.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE INSURER WEBSITE AT www.myuhc.com OR CALL 1-800-445-9090.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	Per Individual: N/A Per Family: N/A	Per Individual: N/A Per Family: N/A

- **There is no deductible.**
- A **deductible** is the amount you are required to pay for covered dental services each policy year before the insurer begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your insurer for alternative rates of payment for dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that have not contracted with your insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	N/A	N/A
Lifetime Maximum for Orthodontia	N/A	N/A

- **Annual maximum** is the maximum dollar amount your policy will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period.
- **Lifetime maximum** means the maximum dollar amount your policy providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits for all or certain dental treatments.

Category	Waiting Period
Diagnostics	No Waiting Period
Preventive	No Waiting Period
Minor Restorative	No Waiting Period
Oral Surgery	No Waiting Period
Endodontics	No Waiting Period
Periodontics	No Waiting Period

Crowns	No Waiting Period
Dentures	No Waiting Period
Ortho	No Waiting Period

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Diagnostics	$0	N/A	Limited to 1 time per 6 months
Bitewing X-ray	Diagnostics	$0	N/A	Limited to 1 series of 4 films in any 6 month period
Cleaning	Preventive	$0	N/A	Limited to 1 time per 6 months
Filling	Minor Restorative	$25	N/A	Multiple restorations on one surface will be treated as a single filling.
Simple Extraction	Oral Surgery	$0	N/A	Limited to 1 time per tooth per lifetime.
Root Canal	Endodontics	$45	N/A	Limited to 1 time per tooth per lifetime.
Scaling and Root Planing	Periodontics	$25	N/A	Limited to 4 quadrants per calendar year.
Ceramic Crown	Crowns	$215	N/A	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
Removable Partial Denture	Dentures	$165	N/A	Limited to 1 time per consecutive 60 months.
Orthodontia	Ortho	$1,895	N/A	

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT.

The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this policy to other dental policies you may be considering. Your actual cost will likely be different from those shown in the chart below 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 the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist		Sam Needs a Tooth Filled		Maria Needs a Crown	
New patient exam, x-rays (FMX) and cleaning		Resin-based composite - one surface, posterior		Crown - porcelain/ceramic substrate	
Dana's Visit	**Dana's Visit**	**Sam's Visit**	**Sam's Visit**	**Maria's Visit**	**Maria's Visit**
Total Cost of Care	In-network: $250 Out-of-network: $450	Total Cost of Care	In-network: $150 Out-of-network: $250	Total Cost of Care	In-network: $950 Out-of-network: $1,400
Deductible	In-network: Per Indiv: N/A Per Family: N/A Out-of-network: Per Indiv: N/A Per Family: N/A	Deductible	In-network: Per Indiv: N/A Per Family: N/A Out-of-network: Per Indiv: N/A Per Family: N/A	Deductible	In-network: Per Indiv: N/A Per Family: N/A Out-of-network: Per Indiv: N/A Per Family: N/A
Annual Maximum (Plan Will Pay)	In-network: N/A Out-of-network: N/A	Annual Maximum (Plan Will Pay)	In-network: N/A Out-of-network: N/A	Annual Maximum (Plan Will Pay)	In-network: N/A Out-of-network: N/A

Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: N/A	Patient Cost (copayment or coinsurance)	In-network: $25 Out-of-network: N/A	Patient Cost (copayment or coinsurance)	In-network: $215 Out-of-network: N/A
In this example, Dana would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: $0 Out-of-network: $450	In this example, Sam would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: $25 Out-of-network: $250	In this example, Maria would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: $215 Out-of-network: $1,400
Summary of what is not covered or subject to a limitation:	Limited to 1 time per 6 months	Summary of what is not covered or subject to a limitation:	Multiple restorations on one surface will be treated as a single filling.	Summary of what is not covered or subject to a limitation:	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.