UHC PPO High Plan Limitations & Exclusions

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 two times per consecutive 12 months.
2. COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to onetime per consecutive 36 months.
3. BITEWING RADIOGRAPHS Limited to one series of films per calendar year.
4. EXTRAORAL RADIOGRAPHS Limited to two films per calendar year.
5. DENTAL PROPHLYAXIS Limited to two times per consecutive 12 months.
6. FLUORIDE TREATMENTS Limited to covered persons under the age of 19 years, and limited to two times per consecutive 12 months.
7. SPACE MAINTAINERS Limited to covered persons under the age of 19 years, limited to one per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
8. Sealants Limited to covered persons under the age of 19 years, and once per first or second permanent molar every consecutive 60 months.
9. RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.
10. PIN RETENTION Limited to two pins per tooth; not covered in addition to cast restoration.
11. INLAYS AND ONLAYS Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
12. CROWNS Limited to one 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 one time per quadrant per consecutive 24 months.
16. ROOT CANAL THERAPY Limited to one time per tooth per lifetime.
17. PERIODONTAL MAINTENANCE Limited to four times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.
18. FULL DENTURES Limited to one time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
19. PARTIAL DENTURES Limited to one 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 six months after the initial insertion. Limited to one 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 one per consecutive six 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. FULL MOUTH DEBRIDEMENT Limited to one time every consecutive 36 months.
24. GENERAL ANESTHESIA Covered only when clinically necessary.
25. OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.
26. PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to one quadrant or site per consecutive 36 months per surgical area.
27. 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 one time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

High PPO Plan Exclusions

Except as may be specifically provided in the Schedule of Covered Dental Services or through a Rider to the Policy, the following are not Covered:

A. Dental Services that are not Necessary.

UHC PPO High Plan Limitations & Exclusions

B. Hospitalization or other facility charges.

C. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

D. 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.

E. Any Dental Procedure not directly associated with dental disease.

F. Any Dental Procedure not performed in a dental setting.

G. 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.

H. Placement of dental implants, implant-supported abutments and prostheses.

I. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

J. Services for injuries or conditions paid for 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.

K. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

L. 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.

M. Replacement of complete dentures, and 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.

N. 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.

O. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

P. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.

Q. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

R. Attachments to conventional removable prostheses or fixed bridgework. This includes semiprecision 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.

S. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

T. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

U. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

V. 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.

W. 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.

X. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

Y. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

Z. In the event that a Non-Network Dentist routinely waives Copayments and/or the Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Deductible are waived is reduced by the amount waived by the Non-Network provider.

AA. Foreign Services are not Covered unless required as an Emergency.

AB. 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.

AC. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.