# Dental Benefits

UNITEDHEALTHCARE

| | IN-NETWORK PPO | OUT-OF-NETWORK PPO |
|---|---|---|
| Annual Deductible (Individual/Family) | $50 / $150 | $50 / $150 |
| Annual Benefit Maximum | $1,500 | $1,500 |
| Preventive Dental Services (cleanings, exams, x-rays) | 100% | 100% |
| Basic Dental Services (fillings, root canal therapy, oral surgery) | 20% | 20% |
| Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs) | 50% | 50% |
| Orthodontic Services | 50% | 50% |
| Dependent children under age 19 | | |
| Orthodontic Lifetime Maximum | $1,000 | $1,000 |

# Vision Benefits

UNITEDHEALTHCARE

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| | UnitedHealthcare Insurance Company | (any qualified non-network provider of your choice) |
| Eye Exam — once every 12 months | $10 Copay | Up to $40 |
| Lenses — once every 12 months | | |
| Polycarbonate lenses for children (once every 24 months) | 100% | N/A |
| Single Vision Lenses | $20 Copay | Up to $40 |
| Lined Bifocal Lenses | $20 Copay | Up to $60 |
| Lined Trifocal Lenses | $20 Copay | Up to $80 |
| Blended Bifocal Lenses | 80% after $20 Copay | N/A |
| Standard Progressive Lenses | Up to $55 after $20 Copay | N/A |
| Frames — once every 24 months | Up to $130 | Up to $45 |
| Contact Lenses — once every 12 months if you elect contacts instead of lenses/ frames | Up to $130 | Up to $105 |

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage

Please register your account at www.myuhc.com