

State Employees Association of North Carolina

NEW! The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under all plans.

	Premium Plan	Core Plan	Basic Plan
Annual Maximum Benefit	\$5,000	In - \$1,500 Out - \$1,250	\$1,250
Orthodontia Lifetime Policy Maximum	\$5,000	Not Covered	Not Covered
Deductible (Individual)	\$50	\$25	\$25
Deductible (Family)	\$150	\$75	\$75
Preventive and Diagnostic Services	High Option Plan	Network Incentive Option	Standard Option Plan
Preventive & Diagnostic Co-Insurance	100%	In - 100% Out - 80%	100%
Oral evaluation Exams (Routine Exam)	2 times per consecutive 12 months	2 times per consecutive 12 months	2 times per consecutive 12 months
Dental Prophylaxis (Teeth Cleaning)	2 times per consecutive 12 months	2 times per consecutive 12 months	2 times per consecutive 12 months
Fluoride Treatments	2 times per consecutive 12 months to age 16	2 times per consecutive 12 months to age 16	2 times per consecutive 12 months to age 16
Intraoral Radiographs (Full Mouth X-rays)	1 time per 36 months (complete series and Panorex)	1 time per 36 months (complete series and Panorex)	1 time per 36 months (complete series and Panorex)
Bitewing and Extraoral X-rays Adults and child(ren)	Bitewing: 1 series per calendar year Extraoral: 2 films per calendar year	Bitewing: 1 series per calendar year Extraoral: 2 films per calendar year	Bitewing: 1 series per calendar year Extraoral: 2 films per calendar year
Basic Services	High Option Plan	Network Incentive Option	Standard Option Plan
Basic Co-Insurance	80%	In - 80% Out - 60%	70%
Sealants	Once per first or second permanent molar every 36 months for dependent children to age 16.	Once per first or second permanent molar every 36 months for dependent children to age 16.	Once per first or second permanent molar every 36 months for dependent children to age 16.
Space maintainers	1 per consecutive 60 months for dependent children to age 16.	1 per consecutive 60 months for dependent children to age 16.	1 per consecutive 60 months for dependent children to age 16.
Simple Extractions	Covered	Covered	Covered
Restorations (Routine Fillings)	Covered	Covered	Covered
Therapeutic Pulpotomy	Covered	Covered	Covered
Periodontal maintenance	2 times per consecutive 12 months following active or adjunctive periodontal therapy	2 times per consecutive 12 months following active or adjunctive periodontal therapy	2 times per consecutive 12 months following active or adjunctive periodontal therapy
Palliative Treatment	Covered	Covered	Covered
Major Services	High Option Plan	Network Incentive Option	Standard Option Plan
Major Co-Insurance	50%	In - 50% Out - 20%	0% Not Covered
Endodontics	Covered	Covered	Not Covered
Denture Repairs	12 months after initial insertion, 1 time per 6 months	12 months after initial insertion, 1 time per 6 months	Not Covered
Adjustment to Dentures	12 months after initial insertion, 1 time per 6 months	12 months after initial insertion, 1 time per 6 months	Not Covered
Oral Surgery	Covered	Covered	Not Covered
Periodontal Scaling and Root Planing	One time per quadrant per consecutive 24 months	One time per quadrant per consecutive 24 months	Not Covered
Root Canal Therapy	1 time per tooth per lifetime	1 time per tooth per lifetime	Not Covered
Periodontal Surgery	Once per quadrant or site every consecutive 36 months	Once per quadrant or site every consecutive 36 months	Not Covered
Oral Surgery - Other/Surgical	Covered	Covered	Not Covered
Anesthesia	Covered as a basic service	Covered as a basic service	Not Covered
Bridges/Dentures	Full Denture/Partial Denture: 1 per consecutive 60 months. Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months.	Full Denture/Partial Denture: 1 per consecutive 60 months. Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months.	Not Covered
Crowns/Inlays/Onlays	1 time per tooth per consecutive 60 months Crown replacement: 1 time per consecutive 60 months from initial or supplemental placement.	1 time per tooth per consecutive 60 months Crown replacement: 1 time per consecutive 60 months from initial or supplemental placement.	Not Covered
Implants Procedures	1 time per tooth per consecutive 60 months	1 time per tooth per consecutive 60 months	Not Covered
Relines and Rebases Dentures	Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months.	Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months.	Not Covered
Occlusal Guards	Covered if prescribed to control habitual grinding	Covered if prescribed to control habitual grinding	Not Covered
Orthodontia	High Option Plan	Network Incentive Option	Standard Option Plan
Orthodontia Co-Insurance	50% (child up to age 19, dependent child to age 25)	0% Not Covered	0% Not Covered

Please refer to the UnitedHealthcare Dental Plan Certificate of Coverage for a detail description of the plan benefits.

Note: The Core Plan is not available to residents in AL, LA, MS or TX.