UnitedHealthcare
Voluntary Options PPO/covered dental services

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table 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 related to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All times 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 Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; UnumAmerica Insurance Company, Milwaukee, Wisconsin; Unum America Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

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<table>
<thead>
<tr>
<th>Covered Services*</th>
<th>Network Plan Pays**</th>
<th>Non-Network Plan Pays***</th>
<th>Benefit Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MAJOR SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inlays/Onlays/Crowns*</td>
<td>0%</td>
<td>0%</td>
<td>Limited to 1 time per tooth per consecutive 60 months.</td>
</tr>
<tr>
<td>Dentures and other Removable Prosthetics</td>
<td>0%</td>
<td>0%</td>
<td>Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.</td>
</tr>
<tr>
<td>Fixed Partial Dentures (Bridges)*</td>
<td>0%</td>
<td>0%</td>
<td>Once per tooth per consecutive 60 months.</td>
</tr>
<tr>
<td><strong>BASIC SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restorations (Amalgam or Anterior Composite)*</td>
<td>100%</td>
<td>100%</td>
<td>Multiple restorations on one surface will be treated as a single filling.</td>
</tr>
<tr>
<td>Emergency Treatment / General Services</td>
<td>0%</td>
<td>0%</td>
<td>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.</td>
</tr>
<tr>
<td>Simple Extractions</td>
<td>0%</td>
<td>0%</td>
<td>Limited to 1 time per tooth per lifetime.</td>
</tr>
<tr>
<td>Oral Surgery (includes surgical extractions)</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Periodontics</td>
<td>0%</td>
<td>0%</td>
<td>Periodontal Maintenance: Limited to 2 times per consecutive 12 months. Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months.</td>
</tr>
<tr>
<td>Endodontics</td>
<td>0%</td>
<td>0%</td>
<td>Root Canal Therapy: Limited to 1 time per tooth per lifetime.</td>
</tr>
<tr>
<td><strong>DIAGNOSTIC SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic Oral Evaluation</td>
<td>100%</td>
<td>100%</td>
<td>Limited to 2 times per consecutive 12 months.</td>
</tr>
<tr>
<td>Radiographs</td>
<td>100%</td>
<td>100%</td>
<td>Bite-wing: Limited to 1 series of films per Plan Year. Complete/Panorex: Limited to 1 time per consecutive 36 months.</td>
</tr>
<tr>
<td>Lab and Other Diagnostic Tests</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>PREVENTIVE SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prophylaxis (Cleanings)</td>
<td>100%</td>
<td>100%</td>
<td>Limited to 2 times per consecutive 12 months.</td>
</tr>
<tr>
<td>Fluoride Treatment (Preventive)</td>
<td>100%</td>
<td>100%</td>
<td>Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.</td>
</tr>
<tr>
<td>Sealants</td>
<td>100%</td>
<td>100%</td>
<td>Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.</td>
</tr>
<tr>
<td>Space Maintainers</td>
<td>100%</td>
<td>100%</td>
<td>For Covered Persons under the age of 16 years, limited to 1 per consecutive 60 months.</td>
</tr>
</tbody>
</table>

* 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 agree 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 fees negotiated with the provider.

***The benefit percentage applies to the schedule of maximum allowable charges. Maximum allowable charges are limitations on billed charges in the geographic area in which the expenses are incurred.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.
General Limitations

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

COMPLET SERIES OR PANOREX RADIOGRAPHS Limited to one time per consecutive 36 months. Exception to this limit will be made for Paronex Radiograph if taken for diagnosis of malocclusion, cysts, or periodontal disease.

BITING RADIOGRAMS Limited to 1 series of films per Plan Year.

EXTRAORAL RADIOGRAPHS Limited to 2 films per Plan Year.

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

FULL MOUTH DEBRIDMENT Limited to 1 time every consecutive 12 months.

OSSEOUS GRAFTS Limited to 1 per quadrant per consecutive 12 months.

DENTAL IMPLANTS Limited to 1 per quadrant per consecutive 12 months.

PALLIATIVE TREATMENT Covered as a separate benefit only if provided without cost to the Covered Person by any provider or family, including spouse, brother, sister, parent or child.

FILLINGS Covered 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.

PARTIAL DENTURES Limited to 1 time every consecutive 60 months.

RELAXING AND REASURING DENTURES Limited to relaxing/relaxing 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 6 months after the initial insertion. Limited to 1 time per consecutive 6 months.

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than x-ray and radiographs, were performed on the same tooth during the visit.

OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.

FULL MOUTH DEBRIDMENT 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 per 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 6 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interocclusal 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 which 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 procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmaceutical 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 pharmaceutical 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 eligible under the Plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, the patient is liable for the cost of replacement.
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 prostheses 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, implants-supported abutments and prostheses. (Not applicable for plans with implants)
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 jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint. (Not Applicable for Plans with TMJ).
24. Acupuncture; acupuncture and other forms of alternative treatment, whether or not used as anestheisa.
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 guard 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.
29. 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 interocclusal orthodontic appliances previously submitted for payment under the plan.
We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** UHC_Civil_Rights@uhc.com

**Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf)


**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your identification card, Monday through Friday, 7 a.m. to 10 p.m. CST.

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

**ATENCIÓN:** Si habla **español** (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

**請注意：**如果您說中文 (**Chinese**), 我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

**XIN LƯU Ý:** Nếu quý vị nói tiếng **Việt** (**Vietnamese**), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

**알림:** 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

**PAALALA:** Kung nagsasalita ka ng **Tagalog** (**Tagalog**), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telefono na nasa iyong identification card.

**ВНИМАНИЕ:** бесплатные услуги перевода доступны для людей, чей родной язык является **русским** (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.
ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d’identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l’italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意到： 日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می‌باشد. لطفاً با شماره تلفن رایگان که روی کارت شناسایی شما فید شده تماس بگیرید.

कृपा ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निश्चित उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टॉल-फ्री फोन नंबर पर काल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

Pakdaar: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lenguage nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

Díí BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáñilti’go, saad bee áka’anída’awo’igii, t’aá jiík’eh, bee ná’ahóóti’i. T’áá shqoqdí ninaaltsoos nitl’izí bee nééhosíngíí bine’déé’ t’aá jiík’ehgo bëésh bee hane’í biká’ígíí bee hodíilníih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.