UnitedHealthcare
Voluntary Options PPO/covered dental services

<table>
<thead>
<tr>
<th>Plan year deductible applies to preventive and diagnostic services</th>
<th>COVERED SERVICES*</th>
<th>NETWORK PLAN PAYS**</th>
<th>NON-NETWORK PLAN PAYS***</th>
<th>BENEFIT GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIAGNOSTIC SERVICES</td>
<td></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>
<td></td>
</tr>
<tr>
<td>Radiographs</td>
<td>100%</td>
<td>100%</td>
<td>Bite-wings: Limited to 1 series of films per Plan Year. Complete/Panorae: Limited to 1 time per consecutive 36 months.</td>
<td></td>
</tr>
<tr>
<td>Lab and Other Diagnostic Tests</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PREVENTIVE SERVICES</td>
<td></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>
<td></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>
<td></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>
<td></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>
<td></td>
</tr>
<tr>
<td>BASIC SERVICES</td>
<td></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>
<td></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>
<td></td>
</tr>
<tr>
<td>Simple Extractions</td>
<td>0%</td>
<td>0%</td>
<td>Limited to 1 time per tooth per lifetime.</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery (includes surgical extractions)</td>
<td>0%</td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontics</td>
<td>0%</td>
<td>0%</td>
<td>Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planning: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 2 times per consecutive 12 months following active and aggressive periodontal therapy, exclusive of gross debridement.</td>
<td></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>
<td></td>
</tr>
<tr>
<td>MAJOR SERVICES</td>
<td></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>
<td></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>
<td></td>
</tr>
<tr>
<td>Fixed Partial Dentures (Bridges)*</td>
<td>0%</td>
<td>0%</td>
<td>Once per tooth per consecutive 60 months.</td>
<td></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 agreed 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.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

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

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 relating 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, the certificate/benefits administrator will govern. All terms 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; Unum Life Insurance Company, Milwaukee, Wisconsin; Unum Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

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**General Limitations**

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

**COMPLETE SERIES ON PANOREX RADIOGRAPHS** Limited to
one time per consecutive 36 months. Exception to this limit will be
made for Panorex Radiograph if taken for diagnosis of
molars, cysts or neoplasms.

**BITEWING RADIOGRAPHS** Limited to 1 series of films per
Plan Year.

**EXTRORAL RADIOGRAPHS** Limited to 2 films per Plan Year.

**DENTAL PROPHYLAXIS** Limited to 2 times per consecutive 12
months.

**FLUORIDE TREATMENTS** Limited to Covered Persons under
the age of 16 years, and limited to 2 times per consecutive 12
months.

**SEALANTS** Limited to Covered Persons under the age of 16
years and once per first or second permanent molar every
consecutive 36 months.

**SPACE MAINTAINERS** Limited to Covered Persons under the
age of 16 years. Limited to 1 per consecutive 60 months.
Benefit includes all adjustment within 6 months of installation.

**RESTORATIONS** Multiple restorations on 1 surface will be
treated as a single filling.

**PIN RETENTION** Limited to 2 pins per tooth; not covered in
addition to cast restoration.

**INLAYS AND ONLAYS** Limited to 1 time per tooth per
consecutive 60 months. Covered only when a filling cannot
restore the tooth.

**CROWNS** Limited to 1 time per tooth per consecutive 60
months. Covered only when a filling cannot restore the tooth.

**POST AND CORES** Covered only for teeth that have had root
canal therapy.

**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.

**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. No additional allowances for precision or semi-
precision attachments.

**PARTIAL DENTURES** Limited to 1 time every consecutive 60
months. No additional allowances for precision or semi-
precision attachments.

**RELINING AND REBASING DENTURES** Limited to relining/rebasings 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
12 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 exam 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 60 months from initial or supplemental placement.
This includes retainers, partials, and any fixed or removable
interceptive 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
   emergencies.
6. Any procedure not performed in a dental setting.
7. 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.
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 began 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,
    pontic, and/or abutment(s) within this 12 month period, the
    plan is responsible only for the procedures associated with the
    addition.
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 prosthetic 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 prosthesis 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, acupressure and other forms of alternative
    treatment, whether or not used as anesthesia
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 interceptive 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 must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your identification card, Monday through Friday, 7 a.m. to 10 p.m. CST. 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  
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)  

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 ID card, TTY 711, 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 libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono 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.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على عضوية.
ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat identifikasyon 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.

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

注意事項： 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。

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 cin qhia tus kheej.

PAAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe 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 yáníilt'go, saad bee áka'anida'awo'ígíí, t'áá jìik'eh, bee ná'ahóó't'. T'áá shǫǫdí ninaaltsoos niit'l'ízi bee néhozinigíí bine'déę' t'áá jìik'ehgo béésh bee hane'i biká'ígíí bee hodíilnih.

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.