UnitedHealthcare
dental plan
Voluntary Options PPO/covered dental services
Custom P6046

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<th>Plan year deductible applies to preventive and diagnostic services</th>
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<td>COVERED SERVICES*</td>
<td>PAYS**</td>
<td>PAYS***</td>
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| DIAGNOSTIC SERVICES                                          | 100%    | 100%      | Limited to 2 times per consecutive 12 months.
| Periodic Oral Evaluation                                     | 100%    | 100%      | Bite-wire: Limited to a series of films per Plan Year. Complete/panorex: Limited to 1 time per consecutive 36 months.
| Radiographs                                                 | 100%    | 100%      | Limited to 2 times per consecutive 12 months.
| Lab and Other Diagnostic Tests                               | 100%    | 100%      | Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
| Preventive Services                                          | 100%    | 100%      | Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
| PROACTIVE SERVICES                                           | 100%    | 100%      | For Covered Persons under the age of 16 years, limited to 1 per consecutive 60 months.
| BASIC SERVICES                                               | 100%    | 100%      | Limited to 2 times per consecutive 12 months.
| Restorations (Amalgam or Anterior Composite)*                | 100%    | 100%      | Multiple restorations on one surface will be treated as a single filling.
| Emergency Treatment / General Services                       | 0%      | 0%        | 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.
| Simple Extractions                                          | 0%      | 0%        | Limited to 1 time per tooth per lifetime.
| Oral Surgery (includes surgical extractions)                 | 0%      | 0%        | Peri-implant Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and root planing: Limited to 1 time to 1 quadrant per consecutive 24 months.
| Periodontics                                                | 0%      | 0%        | Periodontal maintenance: Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
| MAJOR SERVICES                                               | 0%      | 0%        | Root canal therapy: Limited to 1 time per tooth per lifetime.
| Inlays/onlays/crowns*                                        | 0%      | 0%        | Limited to 1 time per tooth per consecutive 60 months.
| Dentures and other removable prosthetics                     | 0%      | 0%        | Full denture/partial denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
| Fixed partial dentures (bridges)*                           | 0%      | 0%        | Once per tooth per consecutive 60 months.

* 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.

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

The material contained in this 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, your 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 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 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.
9. Expenses for dental procedures begun prior to the covered person becoming entitled 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 relationship to the Covered Person, the same individual under the age of 16, same group or organization with the same legal relationship to the Covered Person, any relative of the Covered Person, or any individual related to the Covered Person non-related to provider error. This type of replacement is the 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.
12. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstructions.
13. 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.
14. Procedures related to the reconstruction of a patient’s correct vertical dimension of occlusion (VDO).
15. Placement of dental implants, implants-supported abutments and prostheses. (Not applicable for plans with implants)
16. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
17. 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.
18. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
19. 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).
20. Acupuncture; acupressure and other forms of alternative pressure, whether or not used as anesthesia.
21. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
22. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
23. Occlusal guard used as safety items or to affect performance primarily in sports-related activities.
24. 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.
25. 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.
NON-DISCRIMINATION NOTICE

UnitedHealthcare StudentResources does 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:

Civil Rights Coordinator
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130 UHC_Civil_Rights@uhc.com

You must send the written 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 member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

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 also provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card or 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.
LANGUAGE ASSISTANCE PROGRAM

We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

English
Language assistance services are available to you free of charge. Please call 1-866-260-2723.

Albanian

Amharic
አማርኛ እንዳለ ያለ الأجیر እንደ ከጠበቃ። ለማስታወቂያ 1-866-260-2723 ያቋቋሚዎቹ.

Arabic
تتوفر لك خدمات المساعدة اللغوية مجانية، تصل إلى الرقم 1-866-260-2723.

Armenian
Համարենք քաղաքի և շրջանի բազային ծառայությունները: Համարենք քաղաքի 1-866-260-2723 համագրությամբ.

Bantu- Kirundi
Uronswa ku buntu serivisi zitafiyite ku rurimi zo kugufasha. Utegerezwa guharamanga 1-866-260-2723.

Bisayan- Visayan (Cebuano)

Bengali- Bangla
ভাষা সহায়তা পরিষেবা অপরিসীম বিনামূল্যে পেতে পারেন। যা করুন 1-866-260-2723-বর্তমান ফরাম।

Burmese
သင် ကိုယ်စားလှယ်တို့ အားလုံး ရှာဖွေပေးသည်။ သင် တွေ့ရစေရန် ကိုယ်စားလှယ် 1-866-260-2723 ဖြင့် မြန်မာစိုက်ပျိုးပေးပါ။

Cambodian- Mon-Khmer
កម្ពុជាទូរស័ព្ទទៅកាន់បង្អែមអនុក្រម បង្អែមអនុក្រម 1-866-260-2723 ម្នាក់៖

Cherokee
SPCA110 O9L0SPT W9 RG070toL0HT I1EG6070 DECOT I6GO D06WSP 1-866-260-2723.

Chinese
您可以免費獲得語言援助服務；請致電 1-866-260-2723。

Choctaw
Chahta anumpa ish anumpuli holmvnt toshholi yvt phel pilla hq che apela hinla. I paya 1-866-260-2723.

Cushite- Oromo

Dutch
Taalbijstandsdiesten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

French
Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

French Creole- Haitian Creole

German

Greek
Οι γλωσσικές υπηρεσίες προσφέρονται δωρεάν. Καλείτε στο 1-866-260-2723.

Gujarati
ભાષા સહાયતા સેવાઓ તમામ મહાદે જિલ્લા પ્રાંદ્રિય છે. કોલી કરીને 1-866-260-2723 પર કોલ કરો.

Hawaiian
Kūkua manaahia ma kū ‘ōlelo i loa’a ‘ia. E kelepona i ka helu 1-866-260-2723.

Hindi
आप के लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

Hmong
Muaj kov cey pub bhaas las pub dawb rau koj. Thov hau ruu 1-866-260-2723.

Ibo

Ilocano
Adda awan bayachna a serbisyo para iti language assistance. Pasinggassim tu tawagam ti 1-866-260-2723.

Indonesian

Italian
Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

Japanese
無料の言語支援サービスをご利用いただけます。1-866-260-2723 までお電話ください。

Karen
အားချင်ပြင်မှုကြောင်း အားလုံးတို့အတွက် လာရောက်ပါ။ 1-866-260-2723 မှ အားချင်ပြင်မှုကြောင်းများငါးချင်ပါ။

Korean
언어 지원 서비스는 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

Kru- Bassa
Bot ba holo ni kobol mahop ngui nsaa wogu wo ba ye ha i nyu yo. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani
خزمه‌کلیکی یروسیتی زمانی نیست که نزدیکی دکترین نکاکی تعلق‌ریزیدن که نزدیکی 1-866-260-2723.

Laotian
 البلطيقی میا تایلیابنทای میا لاهیابن یه‌پاگیا. 1-866-260-2723.