**UnitedHealthcare®
Options PPO 20/covered dental services**

<table>
<thead>
<tr>
<th></th>
<th>NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Annual Deductible</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Family Annual Deductible</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td>Annual Maximum Benefit</td>
<td>$1000 per person</td>
<td>$1000 per person</td>
</tr>
<tr>
<td>(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)</td>
<td>per calendar year</td>
<td>per calendar year</td>
</tr>
<tr>
<td>Annual Deductible Applies to Preventive and Diagnostic Services</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Waiting Period</td>
<td>6 months for major services</td>
<td></td>
</tr>
</tbody>
</table>

**COVERED SERVICES***

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>NETWORK PLAN PAYS**</th>
<th>NON-NETWORK PLAN PAYS***</th>
<th>BENEFIT GUIDELINES</th>
</tr>
</thead>
<tbody>
<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>Bitewing: Limited to 1 series of films per calendar 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>Dental Prophylaxis (Cleanings)</td>
<td>100%</td>
<td>100%</td>
<td>Limited to 2 times per consecutive 12 months.</td>
</tr>
<tr>
<td>Fluoride Treatments</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, limit 1 per consecutive 60 months.</td>
</tr>
<tr>
<td><strong>BASIC DENTAL SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restorations (Amalgam or Anterior Composite)*</td>
<td>50%</td>
<td>50%</td>
<td>Multiple restorations on one surface will be treated as a single filling.</td>
</tr>
<tr>
<td>General Services (including Emergency Treatment)</td>
<td>50%</td>
<td>50%</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. Occlusal Guard: Limited to 1 guard every consecutive 36 months.</td>
</tr>
<tr>
<td><strong>MAJOR DENTAL SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inlays/Onlays/Crowns*</td>
<td>50%</td>
<td>50%</td>
<td>Limited to 1 time per tooth per consecutive 60 months.</td>
</tr>
<tr>
<td>Dentures and other Removable Prosthetics</td>
<td>50%</td>
<td>50%</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>50%</td>
<td>50%</td>
<td>Limited to 1 time per tooth 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 have 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 fee negotiated with the provider.

*** The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider.

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 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 Benefits and your Certificate of Coverage/benefits administrator, 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 exclusions and limitations

Dental Services described in this section are covered when such services are:

A. Necessary;
B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
C. The least costly, clinically accepted treatment; and
D. Not excluded as described in the Section entitled, General Exclusions.

<table>
<thead>
<tr>
<th>General Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following are not covered:</td>
</tr>
<tr>
<td>1. Dental Services that are not necessary.</td>
</tr>
<tr>
<td>2. Hospitalization or other facility charges.</td>
</tr>
<tr>
<td>3. Any dental procedure performed solely for cosmetic/esthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)</td>
</tr>
<tr>
<td>4. Reconstructive Surgery except when the surgery is related to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.</td>
</tr>
<tr>
<td>5. Any dental procedure not directly associated with dental disease.</td>
</tr>
<tr>
<td>6. Any dental procedure not performed in a dental setting.</td>
</tr>
<tr>
<td>7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes all procedures not performed in a dental setting.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the Policy.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>11. Services rendered by a provider who is a member of a covered person’s family, including spouse, brother, sister, parent or child.</td>
</tr>
<tr>
<td>12. Services while the insured is outside the United States, its possessions or the countries of Canada and Mexico unless required as an Emergency.</td>
</tr>
<tr>
<td>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 6 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.</td>
</tr>
<tr>
<td>14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been eligible for 6 continuous months.</td>
</tr>
<tr>
<td>15. Replacement of complete dentures, fixed and removable partial dentures, 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.</td>
</tr>
<tr>
<td>16. Fixed or removable prosthetic restoration procedures for complete oral rehabilitation or reconstruction.</td>
</tr>
</tbody>
</table>

**General Limitations**

- **Periodic Oral Evaluation**: Limited to 1 time per consecutive 12 months.
- **Complete Series or Panorax Radiographs**: Limited to 1 time per consecutive 36 months.
- **Bite-wing Radiographs**: Limited to 1 series of films per calendar year.
- **Extraoral Radiographs**: Limited to 2 films per calendar 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.
- **Space Maintainers**: Limited to covered persons under the age of 16 years, and limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
- **Sealants**: Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
- **Restorations**: Multiple restorations on one 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 Core**: 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 Rebasings**: 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 per consecutive 6 months.
- **Palliative Treatment**: Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
- **Occlusal Guards**: Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
- **Full Mouth Debridement**: Limited to 1 time every consecutive 36 months.
- **General Anesthesia**: Covered 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 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, habit appliances, and any fixed or removable interceptive orthodontic appliances.

Plans sold in Texas use associated COC form number: DCOC.CER.06