USF MCOM Housestaff
Insurance Benefits Summary

- Insurance coverage paid for by USF MCOM: Health, Life, Group Disability
- Insurance coverage offered but paid for by employee: Individual Disability, Dental, Vision
- Insurance broker: Muniz and Associates
- Broker contact phone number: 813-258-0033

Health Insurance

- United HealthCare ChoicePlus Plan - UHC Plan Summary
- Online log-in for your health insurance account at www.myuhc.com/ – where you can search providers, see claim details, pharmacy benefits, etc. UHC Welcome Packet
- Tier 1 – USF Housestaff affiliated entities - TGH/Morsani/ACH/Moffitt
    - Most in-patient and out-patient expenses are covered with no co-pay or deductible
    - Some labs and other provider expenses may be submitted as Tier 2
    - Search USF Physicians by specialty here
- Tier 2 – in UHC network – $250 deductible and $2,000/yr. max out of pocket for individuals
- Tier 3 – out of UHC network – $500 deductible and $4,000/yr. max out of pocket for individuals
- Max out-of-pocket for full-family $4,000/yr. in Tier 2 and $8,000/yr. in Tier 3
- Tier 2 and Tier 3 providers can be used across the country
- For more information on Pharmacy Benefits – UHC Pharmacy Guide
- May add spouse for $50/mo and full family for $75/mo – UHC Dependent Enrollment Form
- Any questions or issues with bills from any provider – contact Muniz and Associates

Life Insurance

- Provided by Standard Insurance Company
- $50,000 of group life insurance
- $50,000 of additional benefit for accidental death or dismemberment
- To change your life insurance beneficiary – Life Insurance Beneficiary Form
- Optional individual life coverage available by request - pricing based on amount of benefit, length of coverage, and results of health exam

Group Disability Insurance

- Provided by Standard Insurance Company
- $2,500/month of group long term disability coverage
- Group premiums are paid by USF MCOM
- Benefit amounts, if received, would be taxable to recipient

Individual Disability Insurance

- Individual Disability Insurance available at discounted rates and without medical underwriting
- During your training, you can better protect your income by adding $1,500/mo of individual disability coverage. In-Program Individual Disability Details

Individual Disability Insurance (cont'd.)

- In your last year of training, you may increase the individual disability coverage and take the policy with you (discounts apply for rest of your career)
- Graduate policies start at $2,500/mo for fellowships or $5,000/mo for in-practice and can be increased up to $15,000/mo as your income allows. Graduate Individual Disability Details
- Benefit amounts, if received, would be tax-free to recipient
- Contact Muniz and Associates for more details based on your age, specialty, year of training

Dental Insurance

- Offered through United HealthCare and optional through payroll deduction
- Three optional plans to choose from, 1 HMO and 2 PPO – Dental Vision Enrollment Form
- HMO - have to use network providers, need referrals for specialists, most diagnostic and preventive care at no charge, set benefits for addt'l care, no deductibles, least expensive HMO Details
- PPO – can choose your provider, no need for referrals to see specialists, most diagnostic and preventive care at no charge, uses deductibles, covers larger %'s of costs for more complex care
- Two choices - PPO 20 and PPO 30. Primary difference is that PPO 30 has a higher benefit maximum and covers higher percentages of some services PPO Details

Vision

- Offered through United HealthCare and optional through payroll deduction
- Plan allows for annual eye exams, set of eyeglasses or contacts – Vision Details
- Dental Vision Enrollment Form

United HealthCare

Choice Plus Plan

for USF College of Medicine

	Tier 1 USF	Tier 2UHC In-Network	Tier 3 UHC Out-Of-Network
Plan Features			
■ Physician Services Office Visit Copay	Copay $0	$10 Copay Per Visit	80% after Deductible
■ Specialist Copay	Copay $0	$20 Copay Per Visit	
■ Plan Coinsurance	100%	80%	80%
■ Emergency Room - Copay $0 If Admitted	100%	$50	$50
Urgent Care	100%	100%	80% after Deductible
■ Individual Deductible	Deductible $0	$250	$500
■ Family Deductible	Deductible $0	$500	$1000
■ Hospital Confinement Deductible	Deductible $0	N/A	$250
■ Non-Notification Penalty	Reduction to 50%	Reduction to 50%	Reduction to 50%
■ Individual Out-Of-Pocket	Out of Pocket $0	$2000	$4000
■ Family Out-Of-Pocket	Out of Pocket $0	$4000	$8000
■ Lifetime Maximum	Unlimited	Unlimited	Unlimited
Covered Services			
Physician Office Visits	Copay $0	$10 Copay Per Visit	80% after Deductible
■ Routine Physical Examinations	Copay $0	$10 Copay Per Visit	Not Covered
■ Diagnostic Lab & X-Ray	Copay $0	$10 Copay Per Visit	80% after Deductible
■ Eye Examination\	Copay $0	$10 Copay Per Visit	80% after Deductible
■ Injections in Doctors Office, except for immunizations	Copay $0	$10 Copay Per Visit	80% after Deductible
■ Well Child Care/Immunizations	Copay $0	$10 Copay Per Visit	Not Covered
■ Preventive Care	Copay $0	$10 Copay Per Visit	Not Covered
■ Specialist (Office Visits)	Copay $0	$20 Copay per Visit	80% after Deductible
Outpatient Diagnostic Services ■ Diagnostic, Laboratory And X-Ray	100%	80% after Deductible	80% after Deductible
Outpatient Surgery ■ Outpatient Surgical Center	100%	80% after Deductible	80% after Deductible

United HealthCare

Choice Plus Plan

for USF College of Medicine

	Tier 1 USF	Tier 2UHC In-Network	Tier 3 UHC Out-Of-Network
Outpatient Rehabilitation (In office)			
■ Physical Therapy	Copay $0	$20 Copay	80% after Deductible
■ Occupational Therapy	100%	$20 Copay	80% after Deductible
■ Speech Therapy	100%	$20 Copay	80% after Deductible
■ Spinal Manipulation	Copay $0	$20 Copay	80% after Deductible
20 Visits Of Each Type Per Year			
Hospital Care	100%	80% after Deductible	80% after Deductible
■ Room And Board			
■ Diagnostic Laboratory And X-Ray			
■ Misc. Charges			
Professional Fees - Inpatient	100%	80% after Deductible	80% after Deductible
■ Surgeon/Physicians			
Maternity Care	100%	80% after Deductible	80% after Deductible
■ Physician Prenatal And Postnatal Care			
Emergency Care			
■ Hospital Emergency Room Care (Copay $0 If Admitted)	100%	$50 Copay	$50 Copay
■ Ambulance Services	100%	100%	100%
■ Dental- Accident only	100%	100%	100%
■ Prosthetic Devices	100%	100%	80% after Deductible

United HealthCare

Choice Plus Plan

for USF College of Medicine

	Tier 1 USF	Tier 2UHC In-Network	Tier 3 UHC Out-Of-Network
■ **Durable Medical Equipment**	100%	100%	80% after Deductible
■ **Home Health Care** 40 Visits Per Calendar Year	100%	100%	80% after Deductible
■ **Hospice Services**	100%	100%	80% after Deductible
■ **Skilled Nursing/Extended Care Facility Services** 120 Days Per Calendar Year	100%	100%	80% after Deductible
■ **Transplant Benefits Through United Resource Networks**	100% Through The Program	100% Through The Program	80% after Deductible
■ **Mental Health/Substance Abuse Inpatient**	100%	80% after deductible	80% after deductible
■ **Outpatient**	Individual copay $0 Group Copay $0	$10 Copay	80% after deductible
Prescription Drug Services (Mandatory Generic Program in place 7/1/17)			
Retail Pharmacy:			
■ Retail Generic	$10 Copay	$10 Copay	Not Covered
■ Retail Formulary Brand	$25 copay	$25 Copay	Not Covered
■ Retail Non Formulary Brand	$40 copay	$40 Copay	Not Covered
Mail Order Drugs			
■ Mail Order Generic	$20 copay	$20 Copay	Not Covered
■ Mail Order Formulary Brand	$50 Copay	$50 Copay	Not Covered
■ Mail Order Non Formulary Brand	$80 Copay	$80 Copay	Not Covered
Network Type	Preferred Network	Preferred Network	Not Covered
Generic Drug Policy	Voluntary	Voluntary	Not Covered
Contraceptives – oral,	Covered	Covered	Not Covered

United HealthCare

Choice Plus Plan

for USF College of Medicine

	Tier 1 USF	Tier 2UHC In-Network	Tier 3 UHC Out-Of-Network
diaphragms and self-administered injectibles			

- All plan limits are combined for network and non-network services.
- Deductibles and Out of Pocket limits are separate for in network and out of network and do NOT cross apply.

Welcome

Get the most out of your benefits.

UnitedHealthcare®

What's inside:

Need help?

Visit myuhc.com®.

Sign up for myuhc.com and get a personalized website that gives you access to your health plan details.

Get on-the-go access.

When you're out and about, the UnitedHealthcare **Health4Me®** mobile app puts your health plan at your fingertips. Download it for free today to access your health plan ID card, find nearby care and more.

Call toll-free.

If you don't have computer access, can't find answers, or need language assistance with questions on your benefits, call the toll-free member phone number on your health plan ID card, TTY **711**, 8 a.m. to 8 p.m. ET, Monday through Friday.

Connect with us.

Twitter®: @myUHC • **Facebook®** and **YouTube®**: UnitedHealthcare

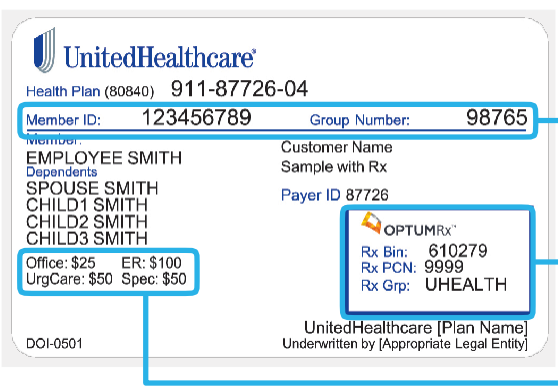
1 Get started.

Thank you for being a UnitedHealthcare member.

We're here to help make each step of your health care experience easier. That's why we've put together this guide, to help you better understand your benefits, find care, manage costs and get more out of your health plan.

Get to know your health plan ID card.

Your health plan ID card has information about you and your coverage. Remember to carry it with you wherever you go. When you visit your doctor or pharmacy, show your card so they know how to bill for their services. You can also access a digital version through the UnitedHealthcare **Health4Me** mobile app. See next page for more information.



Member ID and group number

Use these when registering on myuhc.com or calling with questions.

Your prescription coverage

Your pharmacist will use this to determine what medications are covered.

Your copayment amounts (if applicable)

Your cost for a covered service (usually due at your appointment).

Example only. Your costs may vary.

How to find your plan details.

Log in to myuhc.com to see health plan documents like your policy, riders and amendments, to see what is and is not covered, as well as required notices and welcome materials. You can also request printed copies at no charge by calling the member number on your ID card.

Get started.

1 2 3 4 5

Register for myuhc.com.

Get the most out of your benefits with myuhc.com.

When it comes to managing your health plan and making more informed decisions, simpler is better. With myuhc.com, you have a personalized website that helps you access and manage your health plan. **Use it to:**

- Find and estimate costs for the network care you need.
- See what's covered, and get information about preventive care.
- View claim details and account balances.
- Sign up for paperless delivery of your required plan communications.

Set up your account today.

1. Go to myuhc.com.
2. Click on "Register Now". You'll need your ID card.
3. Follow the step-by-step instructions.

Download the UnitedHealthcare Health4Me mobile app.

Get on-the-go access.

Health4Me puts your health plan at your fingertips. Download the app for free today to:

- Access your health plan ID card.
- Look up your health plan record during your doctor's visit.
- Get directions to quick care options or speak to a doctor.
- Check your current account balances at a glance and estimate costs of common treatments.
- Find drugs and compare prices.

Watch short videos to learn more about your plan.

Visit uhc.com/welcome to watch videos about getting started with your plan, using your benefits and avoiding cost surprises.

2 If you need care.

Find a network provider.

How to find one.

Log in to myuhc.com to find a doctor, clinic, hospital or lab based on location, specialty condition, reputation, estimated cost of services, availability, hours of operation and more. You can even see patient ratings and compare quality and costs before you choose services.

Take advantage of network care.

Network doctors, mental health professionals, hospitals, clinics and laboratories charge discounted rates, which typically saves you money. Even if your plan allows you to receive care outside of your network, be aware that it could cost you more.

Choose with confidence.

The UnitedHealth Premium® Program uses national, evidence-based, standardized measures to evaluate physicians in various specialties to help you locate quality and cost-efficient providers. Find UnitedHealth Premium Care Physicians by going to myuhc.com and clicking on "Find a Doctor." Choose smart. Look for blue hearts.

If you need hospital care.

Talk to your doctor first to determine which hospital in your network can meet your medical or surgical needs. You or your doctor may be required to notify UnitedHealthcare before you're admitted.

Choose a primary care provider (PCP).

Although your plan may not require you to choose a PCP, it's a good idea to have one main doctor with in-depth knowledge of your health. Find one at myuhc.com or call the toll-free member number on your ID card.

Schedule your preventive care screenings.

Most UnitedHealthcare plans pay 100 percent of the cost of certain preventive care services with a network provider. Check your health plan documents for details.

Visit uhcpreventivecare.com to find age- and gender-appropriate preventive care recommendations for everyone covered under your plan.

Finding care when you are traveling.

Call the member phone number on your ID card or use the **Health4Me** app to find providers near you and to learn about your coverage when you travel.

Estimate costs.

Know your potential costs before getting care.

You can find and estimate the price of care you need for an upcoming treatment or procedure on myuhc.com. Your cost estimate shows out-of-pocket expenses based on your plan and current benefit status. Members who comparison shop may save up to 36 percent* for care near them.

*UnitedHealthcare Internal Claims Analysis, 2015.

Prepare for your visit.

What to bring:

- Your ID card and one form of picture ID, such as a driver's license.
- A list of medications you're taking.
- Records from previous visits.
- Questions you want to ask your doctor.

Go mobile.

Download the **Health4Me** app to have what you need for your next doctor's visit, from your ID card to your health record to your list of medications—all in one place.

Health4Me

Using your pharmacy benefits.

OptumRx® is your UnitedHealthcare plan's pharmacy care services provider. We're committed to helping you with easy and cost-effective ways to get the medication you need.

Manage your benefits online.

Log in to your online account at myuhc.com and you can*:

- Set up home delivery.
- Set up medication alerts to remind you when to take your medication and order refills.
- Find a pharmacy near you.
- Confirm the medication you are taking is covered and find out if there is a lower-cost alternative.
- Set up email or text message** medication reminders for when to take your medication and order refills.

Fill your prescriptions.

Delivered to your door.

Order up to a three-month supply of the medication you take regularly. You may pay less with home delivery.

Pick up at the pharmacy.

Show your ID card at any UnitedHealthcare network retail pharmacy.

Go mobile.

Use the **Health4Me** app to:

- Refill home delivery prescriptions.
- Track prescription history.
- Compare medication prices.

Health4Me

*Some sections are only available if you're logged in to your account. Not all sections of the website are available to all members. Access to tools and features is determined by your plan.

**OptumRx provides this service at no additional cost. Standard message and data rates charged by your carrier may apply.

If you need care.

1 2 3 4 5

Lower your pharmacy costs.

When you switch to a new plan, coverage for prescriptions you're already taking may change.

Check your Prescription Drug List (PDL).

The PDL is a list of medications covered by your plan. The list includes both brand-name and generic prescription medications approved by the Food and Drug Administration (FDA). Medications are listed by common categories or classes and placed in tiers that represent the cost you pay out-of-pocket. This makes it easier for you and your doctor to find other options to help you save money.

Know your plan.

Some medications have additional coverage requirements or limits depending on your benefit. Examples may include:

- **Prior authorization** – plan approval to get coverage for a medication.
- **Step therapy** – trying one medication before another.
- **Supply limits** – getting only a certain amount of each prescription.

Your plan may use these requirements to help manage costs or make sure the medication you are taking is clinically appropriate for your condition. See your PDL to find out if your medication has any of these. Then, call the number on your ID card to begin the process.

Compare prices.

Generic medications may have a lower copay than brand-name medications. Ask your doctor if a generic or lower tier option is right for you.

Talk to your doctor.

When you talk to your doctor, use the **Health4Me** app to confirm coverage and costs. You can also discuss what you need to do to get your medication.

Questions? We can help.

- Log in to **myuhc.com**.
- Use the **Health4Me** app.
- Call the number on your ID card.

3 After you receive care.

Know how claims are processed.

When you see a network doctor.

Claims are submitted for you and you may be asked to pay some or all of the bill before you leave. UnitedHealthcare will process the claim to:

- Make sure it's an eligible expense under your plan.
- Make sure the service is paid at the discounted network rate.

When you see an out-of-network doctor.

If your plan allows visits to out-of-network providers, you may be asked to pay some or all of the bill before you leave.

- If the doctor doesn't submit your claim, you may be responsible for submitting the claim.
- Find medical claim forms and instructions on myuhc.com.
- Remember, discounted rates don't apply to out-of-network doctors so you may pay more.

Track your claims online.

Follow your claims from start to finish, and track payments you've made to health care providers in one place. You can also pay your bills online at myuhc.com.

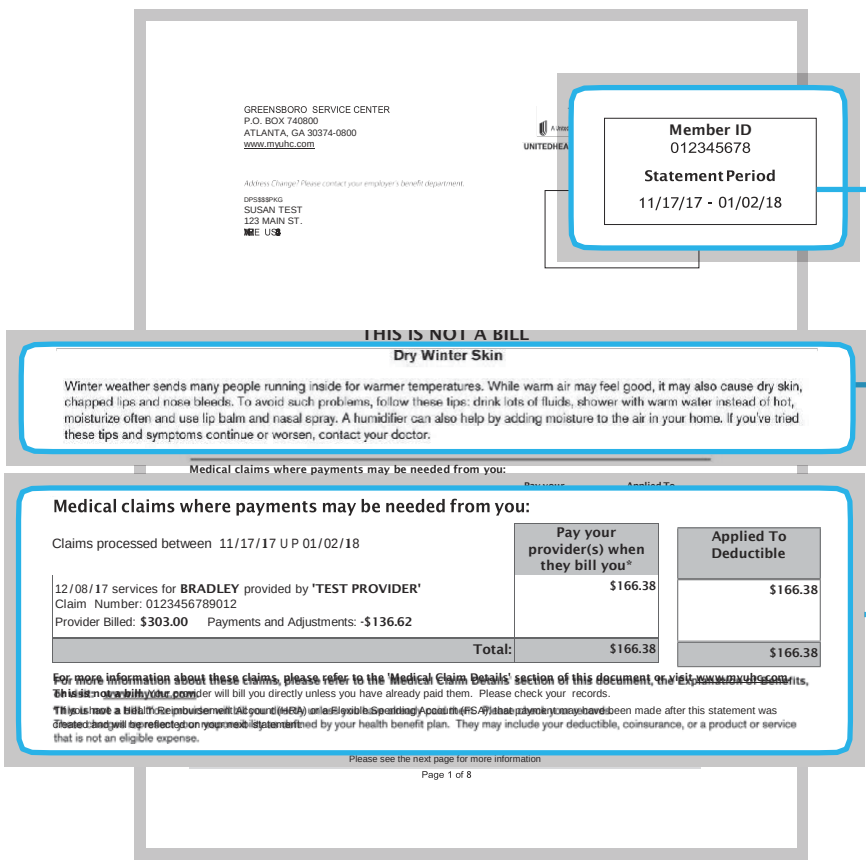
Problem with a claim?

Information about the appeals and grievances process can be found in the "Claims & Accounts" tab on myuhc.com. You can also call the toll-free member number on your ID card, TTY 711.

Understanding your health statements.

We'll send you health statements when you or one of your covered dependents use your health plan. You can see all claims processed for that period, plus your network and out-of-network balance and deductible information.

If you receive your health statements online, you'll get an email whenever a new one is posted. You can view your information and activity securely at myuhc.com.



Member ID

Your unique number that protects your Social Security number.

Statement period

Your health plan statement during a specific time.

Message center

Messages that promote better health awareness.

What you may owe

The amount you need to pay your health care provider if you didn't pay at the time of services, and the portion that's applied to your deductible.

How to submit a complaint.

If you're dissatisfied with the handling of a claim processing issue by UnitedHealthcare or any other experience with UnitedHealthcare, you may file a complaint by calling the toll-free member number on your ID card, or in writing through the Medical Appeals and Grievances information on myuhc.com.

4 Programs to help you.

Health and wellness program.

Sign up for **Rally®** on **myuhc.com**. It's a program to help you move more and eat better. It even rewards you for your progress.

RALLY®

How it works.

Get started.
Once you register, you'll choose an avatar to participate in online communities or other activities.

Take your health survey.
The health survey will guide you with visual prompts to follow. You'll receive your results as a "Rally Age℠"—a number to help you assess your actual age compared to your health age based on your survey responses.

Pick your missions.
Get personalized results and recommended missions— or individual action plans— based on your survey results. Missions provide activities to help improve or maintain your health. Choose ones that fit your lifestyle.

Earn rewards.
You'll get coins when you check in to Rally and track your progress on your missions. Use them to enter sweepstakes for chances to win prizes. The more you participate in Rally, the more chances to win!

Health discounts.

Save 10 percent to 50 percent on these health and wellness products and services that may not be covered by your medical plan:

- Acupuncture, chiropractic care, massage therapy and natural medicine.
- Cosmetic dental teeth whitening.
- Fitness equipment.
- Hearing devices.
- Infertility treatment.
- Laser eye surgery.
- Long-term care services.

Log in to **myuhc.com** to access the health discount program.*

*Health discounts are not available to all health plans.
Check your full plan benefits at **myuhc.com** to see if you are eligible for health discounts.

Pregnancy support.

The Healthy Pregnancy Program provides expectant mothers with support, including health assessments, nurse support and more. It's best to enroll within the first 12 weeks of pregnancy, but you can start through week 34. The program is provided at no extra charge, as part of your health plan. To enroll, call **1-888-246-7389*** or visit **cx.uhc.com/uhcpregnancy** for more information.

*Questions are answered 24/7, but enrollment is only open from 8 a.m. to 8 p.m. CT.

Extra support.

Disease management.

There's additional support for those who need help managing a chronic disease. Resources are available to help you make more informed decisions regarding your health and to help manage your condition. Log in to **myuhc.com** to find the programs offered with your health plan.

Centers of Excellence.

If you have a special condition, you can get help finding a doctor and medical center as well as help with understanding your illness. To see covered conditions, log in to **myuhc.com**.

Emotional health.

Your behavioral health benefit provides confidential support. Get help 24/7 for:

- Alcohol and drug use recovery.
- Coping with grief and loss.
- Depression, anxiety and stress.
- Relationship difficulties.

If you need behavioral health support, visit **liveandworkwell.com** or call the member phone number on your ID card.

5 Rights and responsibilities.

✓ You have the right to:

- Be treated with respect and dignity by UnitedHealthcare personnel, network doctors and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive. See **Notice of Privacy Practices** in your benefit plan documents for a description of how UnitedHealthcare protects your personal health information.
- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your health plan and the care provided to you.
- Get timely responses to your concerns.
- Candidly discuss with your doctor the appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Access doctors, health care professionals and other health care facilities.
- Participate in decisions about your care with your doctor and other health care professionals.
- Get and make recommendations regarding the organization's rights and responsibilities policies.
- Get information about UnitedHealthcare, our services, network doctors and health care professionals.
- Be informed about, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards, when applicable.
- Choose an Advance Directive to designate the kind of care you wish to receive should you become unable to express your wishes.

⚠ Your responsibilities:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your ID card before receiving health care services.
- Pay any necessary copayment at the time you receive treatment.
- Use emergency room services only for injuries and illnesses that, in the judgment of a reasonable person, require immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow the agreed-upon instructions and guidelines of doctors and health care professionals.
- Participate in understanding your health problems and developing mutually agreed-upon treatment goals.
- Notify your employer of any changes in your address or family status.
- Log in to **myuhc.com** or call us when you have a question about your eligibility, benefits, claims and more.
- Log in to **myuhc.com** or call us before receiving services to verify that your doctor or health care professional participates in the UnitedHealthcare network.

Rights and responsibilities.

1 2 3 4 **5**

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

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

Online: UHC_Civil_Rights@uhc.com

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 member phone number listed on your ID card.

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

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

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

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

We provide free services to help you communicate with us such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID 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 telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русский (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 معرّف العضوية.

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 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.

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.

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं. निःशुल्क उपलब्ध है। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka›anída›awo›ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę› t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

Visit **www.uhc.com/legal/required-state-notices** to view important state required notices.

The Health Discount Program is administered by HealthAllies®, Inc., a discount medical plan organization. The Health Discount Program is NOT insurance. The discount program provides discounts at certain health care providers for medical services. The discount program does not make payments directly to the providers of medical services. The discount program member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount plan organization. HealthAllies, Inc., is located at P.O. Box 10340, Glendale, CA, 91209, 1-800-860-8773, **www.unitedhealthallies.com**, oha customercare@optumhealth.com.

Member phone number services should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through the member phone number services are for informational purposes only and provided as part of your health plan. Wellness nurses, coaches and other representatives cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. Member phone number services are not an insurance program and may be discontinued at any time.

Access to Virtual Visits and prescription services may not be available in all states or for all groups. Go to **myuhc.com** for more information about availability of Virtual Visits and prescription services. Always refer to your plan documents for your specific coverage. Virtual Visits are not an insurance product, health care provider or a health plan. Virtual Visits are an Internet-based service provided by contracted UnitedHealthcare providers that allow members to select and interact with independent physicians and other health care providers. It is the member's responsibility to select health care professionals. Care decisions are between the consumer and physician. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations. Members have cost share responsibility and all claims are adjudicated according to the terms of the member's benefit plan. Payment for Virtual Visit services does not cover pharmacy charges; members must pay for prescriptions (if any) separately. No controlled substances may be prescribed. Other prescriptions may be available where clinically appropriate and permitted by law, and can be transmitted to the pharmacy of the member's choice.

Preventive care: Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (PPACA), based on your age, gender and other health factors, with no cost-sharing. The preventive care services covered are those preventive services specified in PPACA. UnitedHealthcare also covers other routine services, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.

Disease Management programs and services may vary on a location-by-location basis and are subject to change with written notice. UnitedHealthcare does not guarantee availability of programs in all service areas and provider participation may vary. Certain items may be excluded from coverage and other requirements or restrictions may apply. If you select a new provider or are assigned to a provider who does not participate in the Disease Management program, your participation in the program will be terminated. Self-Funded or Self-Insured Plans (ASO) covered persons may have an additional premium cost. Please check with your employer.

Some content and materials are for information purposes only, are not intended to be used for diagnosing problems and/or recommending treatment options, and are not a substitute for your doctor's care. Lists of potential treatment options and/or symptoms may not be all-inclusive.

Evaluation of New Technologies: UnitedHealthcare's Medical Technology Assessment Committee reviews clinical evidence that impacts the determination of whether new technology and health services will be covered. The Medical Technology Assessment Committee is composed of Medical Directors with diverse specialties and subspecialties from throughout UnitedHealthcare and its affiliated companies, guest subject matter experts when required, and staff from various relevant areas within UnitedHealthcare. The Committee meets monthly to review published clinical evidence, information from government regulatory agencies and nationally accepted clinical position statements for new and existing medical technologies and treatments, to assist UnitedHealthcare in making informed coverage decisions.

The medical centers and programs in UnitedHealthcare's network and within OptumHealth℠ Care Solutions are independent contractors who render care and treatment to UnitedHealthcare members. UnitedHealthcare does not provide health services or practice medicine. The medical centers and programs are solely responsible for medical judgments and related treatments. UnitedHealthcare is not liable for any act or omission, including negligence, committed by any independent contracted health care professional, medical center or program.

For informational purposes only. Nurse, coach, and EAP services should not be used for emergency or urgent care situations. In an emergency, call 911 or go to the nearest emergency room. The nurse or coach service can't diagnose problems or recommend specific treatment. The information provided by the nurse, coach or EAP services are not a substitute for your doctor's care. On topical articles (giving tips and advice to members), the information and therapeutic approaches in this article are provided for informational and/or educational purposes only. They are not meant to be used in place of professional clinical consultations for individual health needs. Certain treatments may not be covered in some benefit plans. Check your health plan regarding your coverage of services.

All UnitedHealthcare members can access a cost estimator online tool. Depending on your specific benefit plan and the ZIP code that's entered, either the myHealthcare Cost Estimator, or the Treatment Cost Estimator will be available. A mobile version of myHealthcare Cost Estimator is available, and additional ZIP codes and procedures will be added soon. This tool is not intended to be a guarantee of your costs or benefits. Your actual costs and/or benefits may vary. When accessing the tool, please refer to the Terms and Conditions of Use and Why Your Costs May Vary sections for further information regarding cost estimates. Refer to your health plan coverage document for information regarding your specific benefits.

Rally provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services, and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the health survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

This program should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through the program is for informational purposes only and provided as part of your health plan. The wellness team cannot diagnose problems or recommend treatment and is not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. The program is not an insurance program and may be discontinued at any time.

The Healthy Pregnancy Program follows national practice standards from the Institute for Clinical Systems Improvement. The Healthy Pregnancy Program can't diagnose problems or recommend specific treatment. The information provided is not a substitute for your doctor's care.

The UnitedHealth Premium® designation program is a resource for informational purposes only. Designations are displayed in UnitedHealthcare online physician directories at **myuhc.com®**. You should always visit **myuhc.com** for the most current information. **Premium designations are a guide to choosing a physician and may be used as one of many factors you consider when choosing a physician. If you already have a physician, you may also wish to confer with him or her for advice on selecting other physicians. You should also discuss designations with a physician before choosing him or her. Physician evaluations have a risk of error and should not be the sole basis for selecting a physician.** Please visit **myuhc.com** for detailed program information and methodologies

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Information for individuals residing in the state of Louisiana or who have policies issued in Louisiana: Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of these fees for those out-of-network services, in addition to applicable amounts due for copayments, coinsurance, deductibles, and non-covered services. Specific information about in-network and out-of-network facility-based physicians can be found at **myuhc.com** or by calling the toll-free member telephone number that appears on your ID Card.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company. OptumRx is an affiliate of UnitedHealthcare Insurance Company.

D1068 - S700B

Dental Plan Schedule of Benefits

Members of the S700B Dental Plan are eligible to receive benefits immediately upon the Effective Date of coverage with:

- No Waiting Periods
- No Deductibles
- No Claim Forms to Submit

The Member copayments listed are offered by a participating in-network provider. The Member receives:

- Most diagnostic & preventive care at No Charge
- Cosmetic & orthodontia treatment covered

Members can locate a participating provider at

www.myuhc.com

Member Services Department: 800-955-4137

The patient/Member is ultimately responsible for verifications to the accuracy and appropriateness of all fees applicable to any dental benefit provided by a network provider. We urge all of our Members to verify all fees for proposed treatment via the "Schedule of Benefits" and/or with our Member Services Department prior to treatment.

The following Member copayments apply when a participating General Dentist performs services. An "*" denotes limitation on certain benefits (see "Exclusions/Limitations").

CODE	DESCRIPTION	MEMBER'S COPAY
	CLINICAL ORAL EVALUATIONS	
D0120	*Periodic oral evaluation - established patient	No Charge
D0140	Limited oral evaluation - problem focused	No Charge
D0145	*Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge
D0150	*Comprehensive oral evaluation - new or established patient	No Charge
D0160	*Detailed and extensive oral evaluation - problem focused, by report	No Charge
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Charge
D0171	Re-evaluation - post-operative office visit	No Charge
D0180	*Comprehensive periodontal evaluation - new or established patient	No Charge
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	25.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Charge
D9440	Office visit - after regularly scheduled hours	35.00

CODE	DESCRIPTION	MEMBER'S COPAY
D9450	Case presentation, detailed and extensive treatment planning	No Charge
D9986	Missed appointment	25.00
	DIAGNOSTIC IMAGING	
D0210	*Intraoral - complete series (including bitewings)	No Charge
D0220	Intraoral - periapical first radiographic images	4.00
D0230	Intraoral - periapical each additional radiographic images	2.00
D0240	Intraoral - occlusal radiographic images	No Charge
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	No Charge
D0251	*Extra-oral posterior dental radiographic image	No Charge
D0270	*Bitewing - single radiographic images	No Charge
D0272	*Bitewings - two radiographic images	No Charge
D0273	*Bitewings - three radiographic images	No Charge
D0274	*Bitewings - four radiographic images	No Charge
D0277	*Vertical bitewings - 7 to 8 radiographic images	29.00
D0310	Sialography	150.00
D0320	Temporomandibular joint arthrogram, including injection	250.00
D0321	Other temporomandibular joint radiographic images, by report	150.00
D0322	Tomographic survey	150.00
D0330	*Panoramic radiographic images	50.00
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	125.00
D0350	2D oral/facial photographic image obtainedintra-orallyor extra-orally	20.00

CODE	DESCRIPTION	MEMBER'S COPAY
D0364	*Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	169.00
D0365	*Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	149.00
D0366	*Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	139.00
D0367	*Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	139.00
D0368	*Cone beam CT capture and interpretation for TMJ series including two or more exposures	184.00
D0369	*Maxillofacial MRI capture and interpretation	139.00
D0370	*Maxillofacial ultrasound capture and interpretation	189.00
D0371	*Sialoendoscopy capture and interpretation	169.00
D0380	*Cone beam CT image capture with limited field of view - less than one whole jaw	169.00
D0381	*Cone beam CT image capture with field of view of one full dental arch - mandible	149.00
D0382	*Cone Beam CT image capture with field of view of one full dental arch - maxilla, with or without cranium	139.00
D0383	*Cone beam CT image capture with field of view of both jaws, with or without cranium	139.00
D0384	*Cone beam CT image capture for TMJ series including two or more exposures	184.00

CODE	DESCRIPTION	MEMBER'S COPAY
D0385	*Maxillofacial mri image capture	139.00
D0386	*Maxillofacial ultrasound image capture	169.00
D0393	*Treatment simulation using 3d image volume	9.00
D0394	*Digital subtraction of two or more images or image volumes of the same modality	9.00
D0395	*Fusion of two or more 3D image volumes of one or more modalities	9.00
	TESTS AND EXAMINATIONS	
D0415	Collection of microorganisms for culture and sensitivity	No Charge
D0425	Caries susceptibility tests	No Charge
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	65.00
D0460	Pulp vitality tests	No Charge
D0470	Diagnostic casts	No Charge
	ORAL PATHOLOGY LABORATORY	
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Charge
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Charge
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Charge
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	No Charge
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	No Charge
D0502	Other oral pathology procedures, by report	No Charge
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	No Charge
D0601	Caries risk assessment and documentation, with a finding of low risk	No Charge
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No Charge
D0603	Caries risk assessment and documentation, with a finding of high risk	No Charge
	DENTAL PROPHYLAXIS	
D1110	*Prophylaxis - adult	No Charge
D1110	Additional prophylaxis - adult	20.00
D1120	*Prophylaxis - child	No Charge
D1120	Additional prophylaxis - child	20.00
	TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)	
D1206	*Topical fluoride varnish	15.00
D1208	*Topical application of fluoride - excluding varnis	No Charge
D9910	*Application of desensitizing medicament	20.00
	OTHER PREVENTIVE SERVICES	
D1310	Nutritional counseling for control of dental disease	No Charge

CODE	DESCRIPTION	MEMBER'S COPAY
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	*Sealant - per tooth	No Charge
D1352	*Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No Charge
D1353	Sealant repair - per tooth	No Charge
D1354	*Interim caries arresting medicament application	20.00
	SPACE MAINTAINERS (PASSIVE APPLIANCES)	
D1510	*Space maintainer - fixed - unilateral	No Charge
D1515	*Space maintainer - fixed - bilateral	No Charge
D1520	*Space maintainer - removable - unilateral	No Charge
D1525	*Space maintainer - removable - bilateral	No Charge
D1550	Re-cementation or re-bond space maintainer	15.00
D1555	Removal of fixed space maintainer	15.00
D1575	Distal shoe space maintainer – fixed – unilateral	No Charge
	AMALGAMS RESTORATIONS (INCLUDING POLISHING)	
D2140	Amalgam - one surface, primary or permanent	No Charge
D2150	Amalgam - two surfaces, primary or permanent	No Charge
D2160	Amalgam - three surfaces, primary or permanent	No Charge
D2161	Amalgam - four or more surfaces, primary or permanent	No Charge
	RESIN BASED COMPOSITE RESTORATIONS - DIRECT	
D2330	Resin-based composite - one surface, anterior	30.00
D2331	Resin-based composite - two surfaces, anterior	37.00
D2332	Resin-based composite - three surfaces, anterior	50.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	80.00
D2390	Resin-based composite crown, anterior	115.00
D2391	Resin-based composite - one surface, posterior	65.00
D2392	Resin-based composite - two surfaces, posterior	75.00
D2393	Resin-based composite - three surfaces, posterior	90.00
D2394	Resin-based composite - four or more surfaces, posterior	115.00
	GOLD FOIL RESOTRATIONS	
D2410	Gold foil - one surface	75.00
D2420	Gold foil - two surfaces	95.00
D2430	Gold foil - three surfaces	125.00
	INLAY/ONLAY RESTORATIONS	
D2510	Inlay - metallic - one surface	225.00
D2520	Inlay - metallic - two surfaces	235.00
D2530	Inlay - metallic - three or more surfaces	245.00
D2542	Onlay - metallic-two surfaces	325.00
D2543	Onlay - metallic-three surfaces	340.00
D2544	Onlay - metallic-four or more surfaces	350.00
D2610	Inlay - porcelain/ceramic - one surface	275.00*
D2620	Inlay - porcelain/ceramic - two surfaces	300.00*
D2630	Inlay - porcelain/ceramic - three or more surfaces	325.00*
D2642	Onlay - porcelain/ceramic - two surfaces	360.00*
D2643	Onlay - porcelain/ceramic - three surfaces	390.00*
D2644	Onlay - porcelain/ceramic - four or more surfaces	400.00*
D2650	Inlay - resin-based composite - one surface	200.00
D2651	Inlay - resin-based composite - two surfaces	220.00
D2652	Inlay - resin-based composite - three or more surfaces	260.00

CODE	DESCRIPTION	MEMBER'S COPAY
D2662	Onlay - resin-based composite - two surfaces	240.00
D2663	Onlay - resin-based composite - three surfaces	260.00
D2664	Onlay - resin-based composite - four or more surfaces	283.00
	CROWNS - SINGLE RESTORATIONS ONLY	
D2710	*Crown - resin-based composite (indirect)	195.00
D2712	*Crown - ¾ resin-based composite (indirect)	195.00
D2720	*Crown- resin with high noble metal	245.00*
D2721	*Crown - resin with predominantly base metal	245.00*
D2722	*Crown - resin with noble metal	245.00*
D2740	*Crown - porcelain/ceramic substrate per unit applies	245.00*
D2750	*Crown - porcelain fused to high noble metal	245.00*
D2751	*Crown - porcelain fused to predominantly base metal	245.00*
D2752	*Crown - porcelain fused to noble metal	245.00*
D2780	*Crown - 3/4 cast high noble metal	245.00*
D2781	*Crown - 3/4 cast predominantly base metal	245.00*
D2782	*Crown - 3/4 cast noble metal	245.00*
D2783	*Crown - 3/4 porcelain/ceramic	245.00*
D2790	*Crown - full cast high noble metal	245.00*
D2791	*Crown - full cast predominantly base metal	245.00*
D2792	*Crown - full cast noble metal	245.00*
D2794	*Crown - titanium	245.00*
D2799	*Provisional crown - further treatment or completion of diagnosis necessary prior to final impression	125.00
	OTHER RESTORATIVE SERVICES	

CODE	DESCRIPTION	MEMBER'S COPAY
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration	15.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	20.00
D2920	Re-cement or re-bond crown	15.00
D2921	Reattachment of tooth fragment, incisal edge or cusp	15.00
D2929	*Prefabricated porcelain/ceramic crown - primary tooth	49.00*
D2930	Prefabricated stainless steel crown - primary tooth	45.00
D2931	Prefabricated stainless steel crown - permanent tooth	55.00
D2932	Prefabricated resin crown	95.00
D2933	Prefabricated stainless steel crown with resin window	145.00
D2940	Protective restoration	15.00
D2941	Interim therapeutic restoration - primary dentition	15.00
D2949	Restorative foundation for an indirect restoration	20.00
D2950	Core buildup, including any pins when required	70.00
D2951	Pin retention - per tooth, in addition to restoration	15.00
D2952	Post and core in addition to crown, indirectly fabricated	88.00
D2953	Each additional indirectly fabricated post - same tooth	95.00
D2954	Prefabricated post and core in addition to crown	75.00
D2955	Post removal	30.00
D2957	Each additional prefabricated post - same tooth	30.00
D2960	Labial veneer (resin laminate) - chairside	200.00
D2961	Labial veneer (resin laminate) - laboratory	255.00*
D2962	Labial veneer (porcelain laminate) - laboratory	390.00*
D2971	Additional procedures to	45.00

CODE	DESCRIPTION	MEMBER'S COPAY
	construct new crown under existing partial denture framework	
D2975	Coping	95.00
D2980	Crown repair necessitated by restorative material failure	95.00
D2981	Inlay repair necessitated by restorative material failure	95.00
D2982	Onlay repair necessitated by restorative material failure	95.00
D2983	Veneer repair necessitated by restorative material failure	95.00
D2990	Resin infiltration of incipient smooth surface lesions	29.00
	PULP CAPPING	
D3110	Pulp cap - direct (excluding final restoration)	25.00
D3120	Pulp cap - indirect (excluding final restoration)	25.00
	PULPOTOMY	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	30.00
D3221	Pulpal debridement, primary and permanent teeth	95.00
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	75.00
	ENDODONTIC THERAPY ON PRIMARY TEETH	
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	50.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50.00
	ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES & FOLLOW-UP CARE)	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	110.00
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	195.00
D3330	Endodontic therapy, molar (excluding final restoration)	245.00
D3331	Treatment of root canal obstruction; non-surgical access	85.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	75.00
D3333	Internal root repair of perforation defects	125.00
	ENDODONTIC RETREATMENT	
D3346	Retreatment of previous root canal therapy - anterior	300.00
D3347	Retreatment of previous root canal therapy - bicuspid	350.00
D3348	Retreatment of previous root canal therapy - molar	440.00
	APEXIFICATION/RECALCIFICATION PROCEDURES	
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	90.00
D3352	Apexification/recalcification - interim medication replacement	90.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	90.00
	APICOECTOMY/PERIRADICULAR SERVICES	
D3410	Apicoectomy - anterior	100.00
D3421	Apicoectomy - bicuspid (first root)	315.00
D3425	Apicoectomy - molar (first root)	340.00

CODE	DESCRIPTION	MEMBER'S COPAY
D3426	Apicoectomy (each additional root)	95.00
D3427	Periradicular surgery without apicoectomy	100.00
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	47.00
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	42.00
D3430	Retrograde filling - per root	75.00
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	150.00
D3432	Guided tissue regeneration in conjunction with per site, in conjunction with periradicular surgery	150.00
D3450	Root amputation - per root	110.00
D3460	Endodontic endosseous implant	545.00
D3470	Intentional reimplantation (including necessary splinting)	175.00
	OTHER ENDODONTIC PROCEDURES	
D3910	Surgical procedure for isolation of tooth with rubber dam	95.00
D3920	Hemisection (including any root removal), not including root canal therapy	90.00
D3950	Canal preparation and fitting of preformed dowel or post	75.00
	SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	175.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	81.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	49.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	195.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	185.00
D4245	Apically positioned flap	150.00
D4249	Clinical crown lengthening - hard tissue	230.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	375.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	325.00
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	450.00
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	325.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration	325.00
D4266	Guided tissue regeneration - resorbable barrier, per site	325.00
D4267	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	325.00

CODE	DESCRIPTION	MEMBER'S COPAY
D4268	Surgical revision procedure, per tooth	No Charge
D4270	Pedicle soft tissue graft procedure	250.00
D4273	Autogenous connective tissue graft procedures (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	335.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	125.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	502.00
D4276	Combined connective tissue and double pedicle graft, per tooth	65.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	215.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	75.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	299.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	392.00
	NON SURGICAL PERIODONTAL SERVICE	
D4320	Provisional splinting - intracoronal	115.00
D4321	Provisional splinting - extracoronal	105.00
D4341	*Periodontal scaling and root planing - four or more teeth per quadrant	50.00†
D4342	*Periodontal scaling and root planing - one to three teeth per quadrant	43.00†
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	50.00
D4355	*Full mouth debridement to enable comprehensive evaluation and diagnosis	50.00†
D4381	*Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	60.00†
	OTHER PERIODONTAL SERVICES	
D4910	*Periodontal maintenance	50.00
D4910	Additional Periodontal maintenance procedures	100.00
D4920	Unscheduled dressing change (by someone other than treating dentist)	25.00
D4921	Gingival irrigation - per quadrant	15.00
D4999	Unspecified periodontal procedure, by report	No Charge
	COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)	
D5110	*Complete denture -	325.00*

CODE	DESCRIPTION	MEMBER'S COPAY
	maxillary	
D5120	*Complete denture - mandibular	325.00*
D5130	*Immediate denture – maxillary	350.00*
D5140	*Immediate denture – mandibular	350.00*
	PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)	
D5211	*Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	400.00*
D5212	*Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	400.00*
D5213	*Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	425.00*
D5214	*Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	425.00*
D5221	*Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	420.00*
D5222	*Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	420.00*
D5223	*Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	445.00*
D5224	*Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	445.00*
D5225	*Maxillary partial denture - flexible base (including any clasps, rests and teeth)	425.00*
D5226	*Mandibular partial denture - flexible base (including any clasps, rests and teeth)	425.00*
D5281	*Removable unilateral partial denture - one piece cast metal (including clasps and teeth	245.00*
	ADJUSTMENTS TO DENTURES	
D5410	Adjust complete denture - maxillary	15.00
D5411	Adjust complete denture - mandibular	15.00
D5421	Adjust partial denture - maxillary	15.00
D5422	Adjust partial denture - mandibular	15.00
	REPAIRS TO COMPLETE DENTURES	
D5511	*Repair broken complete denture base, mandibular	35.00*
D5512	*Repair broken complete denture base, maxillary	35.00*
D5520	*Replace missing or broken teeth - complete denture (each tooth)	35.00*
	REPAIRS TO PARTIAL DENTURES	
D5611	*Repair resin partial denture base, mandibular	35.00*
D5612	*Repair resin partial denture base, maxillary	35.00*
D5621	*Repair cast partial framework, mandibular	35.00*
D5622	*Repair cast partial framework, maxillary	35.00*
D5630	*Repair or replace broken clasp – per tooth	35.00*
D5640	*Replace broken teeth - per tooth	35.00*
D5650	*Add tooth to existing partial denture	35.00*
D5660	*Add clasp to existing partial denture – per tooth	35.00*
D5670	*Replace all teeth and acrylic on cast metal framework (maxillary)	155.00*
D5671	*Replace all teeth and acrylic on cast metal framework (mandibular)	155.00*

CODE	DESCRIPTION	MEMBER'S COPAY
D5710	*Rebase complete maxillary denture	135.00*
D5711	*Rebase complete mandibular denture	135.00*
D5720	*Rebase maxillary partial denture	155.00*
D5721	*Rebase mandibular partial denture	155.00*
D5730	*Reline complete maxillary denture (chairside)	65.00*
D5731	*Reline complete mandibular denture (chairside)	65.00*
D5740	*Reline maxillary partial denture (chairside)	65.00*
D5741	*Reline mandibular partial denture (chairside)	65.00*
D5750	*Reline complete maxillary denture (laboratory)	85.00*
D5751	*Reline complete mandibular denture (laboratory)	85.00*
D5760	*Reline maxillary partial denture (laboratory)	85.00*
D5761	*Reline mandibular partial denture (laboratory)	85.00*
	INTERIM PROSTHESIS	
D5810	*Interim Complete denture (maxillary)	250.00*
D5811	*Interim complete denture (mandibular)	250.00*
D5820	*Interim partial denture (maxillary)	175.00*
D5821	*Interim partial denture (mandibular)	175.00*
	OTHER REMOVABLE PROSTHESIS	
D5850	Tissue conditioning, maxillary	20.00
D5851	Tissue conditioning, mandibular	20.00
D5862	Precision attachment, by report	150.00
D5899	Unspecified removable prosthodontic procedure, by report	No Charge
	NON-CLINICAL PROCEDURES	
D5982	Surgical stent	150.00*
D5987	Commissure splint	150.00*
D5988	Surgical splint	150.00*
	PRE-SURGICAL SERVICES	
D6190	Radiographic/surgical implant index, by report	235.00
	SURGICAL SERVICES	
D6010	*Surgical placement of implant body	1010.00
D6012	*Surgical placement of interim body for transitional prosthesis	1010.00
D6100	Implant removal, by report	700.00
	IMPLANT SUPPORTED PROSTHETICS	
D6056	*Prefabricated Abutment	440.00
D6057	*Custom Abutment	550.00
D6058	*Abutment supported porcelain/ceramic crown	750.00
D6059	*Abutment supported porcelain fused to metal crown (high noble metal)	750.00
D6060	*Abutment supported porcelain fused to metal crown (predominantly base metal)	750.00
D6061	*Abutment supported porcelain fused to metal crown (noble metal)	750.00
D6062	*Abutment supported cast metal crown (high noble metal)	750.00
D6063	*Abutment supported cast metal crown (predominantly base metal)	750.00
D6064	*Abutment supported cast metal crown (noble metal)	750.00
D6065	*Implant supported porcelain/ceramic crown	750.00
D6066	*Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	750.00
D6067	*Implant supported metal crown (titanium, titanium alloy, high noble metal)	750.00
D6068	*Abutment supported retainer for porcelain/ceramic FPD	750.00

CODE	DESCRIPTION	MEMBER'S COPAY
D6069	*Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	750.00
D6070	*Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	750.00
D6071	*Abutment supported retainer for porcelain fused to metal FPD (noble metal)	750.00
D6072	*Abutment supported retainer for cast metal FPD (high noble metal)	750.00
D6073	*Abutment supported retainer for cast metal FPD (predominantly base metal)	750.00
D6074	*Abutment supported retainer for cast metal FPD (noble metal)	750.00
D6075	*Implant supported retainer for ceramic FPD	750.00
D6076	*Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	750.00
D6077	*Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	750.00
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	50.00†
D6085	Provisional implant crown	125.00
D6094	*Abutment supported crown - (titanium)	750.00
D6096	Remove broken implant retaining screw	500.00
D6110	*Implant/abutment supported removable denture for edentulous arch – maxillary	1255.00
D6111	*Implant/abutment supported removable denture for edentulous arch – mandibular	1255.00
D6112	*Implant/abutment supported removable denture for partially edentulous arch – maxillary	995.00
D6113	*Implant/abutment supported removable denture for partially edentulous arch – mandibular	995.00
D6114	*Implant/abutment supported fixed denture for edentulous arch – maxillary	3855.00
D6115	*Implant/abutment supported fixed denture for edentulous arch – mandibular	3855.00
D6116	*Implant/abutment supported fixed denture for partially edentulous arch – maxillary	2255.00
D6117	*Implant/abutment supported fixed denture for partially edentulous arch – mandibular	2255.00
D6118	*Implant/abutment supported interim fixed denture for edentulous arch – mandibular	1804.00
D6119	*Implant/abutment supported interim fixed denture for edentulous arch – maxillary	1804.00
	OTHER IMPLANT SERVICES	
D6080	Implant maintenance procedures, including removal	180.00
D6090	Repair implant suported prosthesis, by report	400.00
D6092	Recement implant/abutment crown	45.00
D6093	Recement implant/abutment supported fixed partial denture	No Charge
D6095	Repair implant abutment, by report	220.00
	FIXED PARTIAL DENTURE PONTICS	

CODE	DESCRIPTION	MEMBER'S COPAY
D6205	*Pontic - indirect resin based composite	750.00
D6210	*Pontic - cast high noble metal	245.00*
D6211	*Pontic - cast predominantly base metal	245.00*
D6212	*Pontic - cast noble metal	245.00*
D6214	*Pontic - titanium	245.00*
D6240	*Pontic - porcelain fused to high noble metal	245.00*
D6241	*Pontic - porcelain fused to predominantly base metal	245.00*
D6242	*Pontic - porcelain fused to noble metal	245.00*
D6245	*Pontic - porcelain/ceramic	245.00*
D6250	*Pontic - resin with high noble metal	245.00*
D6251	*Pontic - resin with predominantly base metal	245.00*
D6252	*Pontic - resin with noble metal	245.00*
D6253	*Provisional Pontic - further treatment or completion of diagnosis necessary prior to final impression	No Charge
	FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS	
D6545	Retainer - cast metal for resin bonded fixed prosthesis	390.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	225.00*
D6600	Retainer inlay - porcelain/ceramic, two surfaces	245.00*
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	245.00*
D6602	Retainer inlay - cast high noble metal, two surfaces	245.00*
D6603	Retainer inlay - cast high noble metal, three or more surfaces	245.00*
D6604	Retainer inlay - cast predominantly base metal, two surfaces	245.00*
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	245.00*
D6606	Retainer inlay - cast noble metal, two surfaces	245.00*
D6607	Retainer inlay - cast noble metal, three or more surfaces	245.00*
D6608	Retainer onlay - porcelain/ceramic, two surfaces	245.00*
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	245.00*
D6610	Retainer onlay - cast high noble metal, two surfaces noble metal, three or more surfaces	245.00*
D6611	Retainer onlay - cast high	245.00*
D6612	Retainer onlay - cast predominantly base metal, two surfaces	245.00*
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	245.00*
D6614	Retainer onlay - cast noble metal, two surfaces	245.00*
D6615	Retainer onlay - cast noble metal, three or more surfaces	245.00*
D6624	Retainer inlay - titanium	245.00*
D6634	Retainer onlay - titanium	245.00*
	FIXED PARTIAL DENTURE RETAINERS - CROWNS	
D6710	*Retainer crown - indirect resin based composite	245.00*
D6720	*Retainer crown - resin with high noble metal	245.00*
D6721	*Retainer crown - resin with predominantly base metal	245.00*
D6722	*Retainer crown - resin with noble metal	245.00*
D6740	*Retainer crown - porcelain/ceramic	245.00*
D6750	*Retainer crown - porcelain fused to high noble metal	245.00*
D6751	*Retainer crown - porcelain fused to predominantly base metal	245.00*

CODE	DESCRIPTION	MEMBER'S COPAY
D6752	*Retainer crown - porcelain fused to noble metal	245.00*
D6780	*Retainer crown - 3/4 cast high noble metal	245.00*
D6781	*Retainer crown - 3/4 cast predominantly base metal	245.00*
D6782	*Retainer crown - 3/4 cast noble metal	245.00*
D6783	*Retainer crown - 3/4 porcelain/ceramic	245.00*
D6790	*Retainer crown - full cast high noble metal	245.00*
D6791	*Retainer crown - full cast predominantly base metal	245.00*
D6792	*Retainer crown - full cast noble metal	245.00*
D6793	*Provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	125.00
D6794	*Retainer crown - titanium	245.00*
	OTHER FIXED PARTIAL DENTURE SERVICES	
D6930	Re-cement or re-bond fixed partial denture	15.00
D6940	Stress breaker	125.00
D6950	Precision attachment	195.00
D6980	Fixed partial denture repair necessitated by restorative material failure	80.00
	EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POST OPERATIVE CARE)	
D7111	Extraction, coronal remnants - deciduous tooth	50.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	20.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	30.00
	OTHER SURGICAL PROCEDURES	
D7220	Removal of impacted tooth - soft tissue	50.00
D7230	Removal of impacted tooth - partially bony	65.00
D7240	Removal of impacted tooth - completely bony	80.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	135.00
D7250	Removal of residual tooth roots (cutting procedure)	40.00
D7251	Cronectomy - intentional partial tooth removal	270.00
D7260	Oroantral fistula closure	160.00
D7261	Primary closure of a sinus perforation	275.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	100.00
D7280	Exposure of an unerupted tooth	125.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	125.00
D7283	Placement of device to facilitate eruption of impacted tooth	80.00
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	125.00
D7286	Incisional biopsy of oral tissue-soft	85.00
D7287	Exfoliative cytological sample collection	75.00
D7288	Brush biopsy - transepithelial sample collection	25.00
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	40.00
	ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE	
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	40.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	40.00
D7320	Alveoloplasty not in conjunction with extractions –four or more teeth or tooth spaces, per quadrant	60.00
D7321	Alveoloplasty not in	60.00

CODE	DESCRIPTION	MEMBER'S COPAY
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	990.00
	SURGICAL EXCISION OF SOFT TISSUE LESIOINS	
D7410	Excision of benign lesion up to 1.25 cm	25.00
D7411	Excision of benign lesion greater than 1.25 cm	50.00
D7412	Excision of benign lesion, complicated	55.00
	SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	65.00
	EXCISION OF BONE TISSUE	
D7471	Removal of lateral exostosis (maxilla or mandible)	95.00
D7472	Removal of torus palatinus	95.00
D7473	Removal of torus mandibularis	95.00
D7485	Reduction of osseous tuberosity	95.00
	SURGICAL INCISION	
D7510	Incision and drainage of abscess - intraoral soft tissue	20.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	20.00
D7520	Incision and drainage of abscess - extraoral soft tissue	20.00
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	20.00
	REPAIR OF TRAUMATIC WOUNDS	
D7910	Suture of recent small wounds up to 5 cm	35.00
	OTHER REPAIR PROCEDURES	
D7921	Collection and application of autologous blood concentrate product	125.00
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogeneous or nonautogeneous, by report	350.00
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	800.00
D7952	Sinus augmentation via a vertical approach	350.00
D7953	Bone replacement graft for ridge preservation – per site	100.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	105.00
D7963	Frenuloplasty	105.00
D7970	Excision of hyperplastic tissue - per arch	140.00
D7971	Excision of Pericoronal Gingiva	102.00
D7972	Surgical reduction of fibrous tuberosity	125.00
	LIMITED ORTHODONTIC TREATMENT	
D8010	Limited orthodontic treatment of the primary dentition	1000.00
D8020	Limited orthodontic treatment of the transitional dentition	1000.00
D8030	Limited orthodontic treatment of the adolescent dentition	1000.00
D8040	Limited orthodontic treatment of the adult dentition	1350.00
	COMPREHENSIVE ORTHODONTIC TREATMENT	
D8070	Comprehensive orthodontic treatment of the transitional dentition	2200.00
D8080	Comprehensive orthodontic treatment of the adolescent	2250.00

CODE	DESCRIPTION	MEMBER'S COPAY
	dentition	
D8090	Comprehensive orthodontic treatment of the adult dentition	2350.00
	MINOR TREATMENT TO CONTROL HARMFUL HABITS	
D8210	Removable appliance therapy	103.00
D8220	Fixed appliance therapy	103.00
	OTHER ORTHODONTIC SERVICES	
D8660	Pre-orthodontic treatment examination to monitor growth and development	35.00
D8670	Periodic orthodontic treatment visit	No Charge
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	300.00
D8681	Removable orthodontic retainer adjustment	No Charge
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	No Charge
D8999	Unspecified orthodontic procedure, by report	250.00
	UNCLASSIFIED TREATMENT	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	No Charge
D9120	Fixed partial denture sectioning	No Charge
	ANESTHESIA	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	No Charge
D9211	Regional block anesthesia	No Charge
D9212	Trigeminal division block anesthesia	No Charge
D9215	Local anesthesia	No Charge
D9222	Deep sedation/general anesthesia – first 15 minutes	50.00
D9223	Deep sedation/general anesthesia – each 15 minute increment	50.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	20.00
D9239	Intravenous moderate (conscious)	65.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	65.00
D9248	Non-intravenous conscious sedation	15.00
	DRUGS	
D9610	Therapeutic parenteral drug, single administration	15.00
D9630	Drugs or medicaments dispensed in the office for home use	15.00
	MISCELLANEOUS SERVICES	
D9910	*Application of desensitizing medicament	20.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	No Charge
D9932	Cleaning and inspection of removable complete denture, maxillary	No Charge
D9933	Cleaning and inspection of removable complete denture, mandibular	No Charge
D9934	Cleaning and inspection of removable partial denture, maxillary	No Charge
D9935	Cleaning and inspection of removable partial denture, mandibular	No Charge
D9940	*Occlusal guard, by report	250.00
D9942	Repair and/or reline of Occlusal guard	40.00
D9943	Occlusal guard adjustment	25.00
D9950	Occlusion analysis - mounted case	75.00
D9951	Occlusal adjustment - limited	30.00
D9952	Occlusal adjustment - complete	100.00
D9973	External bleaching - per tooth	30.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	240.00

CODE	DESCRIPTION	MEMBER'S COPAY
D9991	Dental case management – addressing appointment compliance barriers	No Charge
D9992	Dental case management – care coordination	No Charge
D9993	Dental case management – motivational interviewing	No Charge
D9994	Dental case management – patient education to improve oral health literacy	No Charge

SPECIALTY SERVICES

1. This Member Schedule of Benefits applies when listed dental services are performed by a participating General Dentist, unless otherwise authorized by Solstice.
2. Procedures not listed on the Schedule of Benefits that are performed by a participating General Dentist will be charged at the participating General Dentist's usual and customary fee less 25%.
3. The Network General Dentist you select may not perform all procedures listed. The Co-payments shown apply to Network General Dentists.
4. Should the services of a Network Specialty Dentist (NSD) (Oral Surgeon, Endodontist, Periodontist, or Pediatric Dentist) be necessary, you may receive this care in either of two ways: (1) You may go directly to a NSD with no referral and receive a 25% reduction off the provider's Usual and Customary Fee; or (2) You may obtain prior written authorization from Solstice and receive specialty treatment by an approved a NSD at the listed Co-payments. Please refer to the Specialty Care Referral Policy in your Member handbook.
5. Should the services of an Orthodontist be necessary, you may receive care in either of two ways: (1) You may go directly to a NSD with no referral and receive a 25% reduction off the provider's Usual and Customary Fee; or (2) You may contact Member Services to locate your nearest participating Orthodontist who will perform covered services at the listed member Co-payment.
6. Members seeking implant treatment should refer to their participating implantologist, a select Network of Participating Providers. Not all providers perform the implant procedures at the Co-payment listed on the Schedule of Benefits. Please refer to the provider listing at www.myuhc.com under "Locate A Provider."

EXCLUSIONS

1. Services performed by a dentist or dental specialist, not contracted with Solstice without prior approval.
2. Any dental services or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the Member's dental health or experimental in nature, as determined by the participating Solstice dentist.
3. Orthographic surgery or procedures and appliances for the treatment of myofunctional, myoskeletal or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits.
4. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions, or medications.
5. Treatment of malignancies, cysts, or neoplasms, without proof of medical necessity and prior Solstice approval.
6. Dental procedures initiated prior to the Member's eligibility under this benefit plan or started after the Member's termination from the plan.
7. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the Member, including but not limited to, physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.

LIMITATIONS

1. Any oral evaluation (excluding problem) is limited to One (1) time per consecutive six (6) months; Comprehensive exams can only be covered one (1) time per 36 months, if and only if patient is considered to be new or an established patient. All subsequent oral evaluations will be at a 25% reduction off the dentist's usual and customary fee without a frequency limitation
2. All bitewing X-rays are limited to one set in any twelve (12) consecutive month period.
3. The dental prophylaxis or periodontal maintenance procedure is limited to one (1) time in any consecutive six (6) month period. Any additional procedures will follow D1110 and D4910 Member copayments as listed in the Schedule of Benefits.
4. Fluoride treatment is limited to one (1) in any twelve (12) consecutive month period.
5. Sealants (D1351 or D1352) are limited to one (1) time per tooth in any three (3) consecutive year period. This is only allowed for unrestored permanent molar teeth for children under the age of 16.
6. Space maintainers and all adjustments are limited to children under the age of 16.
7. Harmful habit appliances are limited to one (1) time per person under the age of 16.
8. General anesthesia or IV sedation is available when listed on the Schedule of Benefits, medically necessary, and previously approved by Solstice.
9. New dentures include one (1) reline within the first six (6) months
10. Replacement of crowns, implants, and fixed bridges or dentures is limited to one (1) time every consecutive five (5) years.
11. When crown, implant and/or bridgework exceed six (6) consecutive units, there will be an additional charge of $30.00 per unit.
12. "Copayments marked by '*' do not include the cost of material and laboratory fees. Additional cost to patient is as follows:
    - High noble metal (precious) up to $145.00
    - Titanium metal up to $120 (covered with proof of allergy to other metals)
    - Noble metal (semi-precious) up to $120.00
    - Predominantly base metal (non-precious) up to $55.00
    - Crown laboratory fees up to $155.00
    - Laboratory fees on dentures up to $225.00
    - Porcelain laboratory fees for D2610-D2644, D2929, D2961, D2962, D6600, D6601, D6608, and D6609 up to $65.00
    - Denture repair laboratory fees up to $50.00
    - All ceramic and/or porcelain crown material fees up to $155.00"
13. Copayments marked by "†" are not eligible at a specialist.
14. Either D0210, D0251, or D0330 are reimbursable one (1) time every five (5) consecutive years.
15. Copies of X-rays can be obtained for $2 per periapical image up to a maximum of $30. Panoramic X-ray can be obtained for a $15 fee.
16. D0274, D0277 or D0210 are payable only when other inclusive image has not been taken (paid) within the last six (6) months.
17. All denture adjustment fees are for dentures which were not fabricated at the present office; All denture adjustment for new dentures made within 12 months are at no fee to the member.
18. Emergency treatment is available for palliative treatment for the abatement of pain up to $100.00 per occurrence.
19. Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general dentists or specialists usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to

facilitate eruption are available at a 25% reduction off of the doctor's usual and customary fees.

20. Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in cost for the enhanced treatment.
21. Occlusal Guard(s) is limited to one (1) time in any consecutive thirty-six (36) months for the purposes of habitual grinding/Bruxism.
22. D0364-D0395 is limited to one (1) time per sixty (60) months, covered only in a dental setting and not in a radiographic imaging center.

USF College of Medicine

Benefit Plan Year 7/1/2018 - 6/30/2021

UnitedHealthcare®

Vision Benefit Summary

Customer Service and Provider Locator: (800) 638-3120

myuhcvision.com

UnitedHealthcare vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.
In-network, covered-in-full benefits (up to the plan allowance and after applicable copay) include a comprehensive exam, eyeglasses with standard single vision, lined bifocal, lined trifocal, or lenticular lenses, standard scratch-resistant coating and the frame, or contact lenses in lieu of eyeglasses.

	Exam with Materials
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses in Lieu of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$ 10.00
Materials	$ 10.00
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)[1]	
Private Practice Provider	$130.00 retail frame allowance
Retail Chain Provider	$130.00 retail frame allowance
Lens Options	
Standard Scratch-resistant Coating,Polycarbonate Lenses for Dependent Children (up to age 19) - covered in full. Other optional lens upgrades may be offered at a discount (discount varies by provider). The Lens Options list can be found at myuhcvision.com.	
Contact Lens Benefit[2] (Selection contact lenses refers to our formulary contact list. Contact lenses not listed on the formulary are referred to as non-selection. A copy of the list can be found at myuhcvision.com).	
Selection contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay (if applicable).	If you choose disposable contacts, up to 4 boxes are included when obtained from an in-network provider.
Non-selection contact lenses An allowance is applied toward the purchase of contact lenses outside the selection. Materials copay (if applicable) is waived.	$105.00
Necessary contact lenses[3]	Covered in full after copay (if applicable).
Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up to $40.00
Frames	Up to $45.00
Single Vision Lenses	Up to $40.00
Lined Bifocal Lenses	Up to $60.00
Lined Trifocal Lenses	Up to $80.00
Lenticular Lenses	Up to $80.00
Elective Contacts in Lieu of Eyeglasses[2]	Up to $105.00
Necessary Contacts in Lieu of Eyeglasses[3]	Up to $210.00

Discounts	
	Laser vision UnitedHealthcare has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off standard or 5% off promotional pricing at more than 550 network provider locations and even greater discounts through set pricing at Lasik*Plus*® locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com.
	Additional Material At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.
	Hearing Aids As a UnitedHealthcare vision plan member, you can save on high-quality hearing aids when you buy them from hi HealthInnovations™. To find out more go to hiHealthInnovations.com. When placing your order use promo code myVision to get the special price discount.

[1]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.
[2]Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames. Coverage for Selection contact lenses does not apply at Costco, Walmart or Sam's Club locations. The allowance for Non-selection contact lenses applies to materials. No portion will be exclusively applied to the fitting and evaluation.
[3]Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, facial deformity; or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare selection.
- Your $105.00 contact lens allowance applies to materials. No portion will be exclusively applied to the fitting and evaluation. Your material copay is waived when purchasing non-selection contacts.
- Patient options such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers. The Lens Options list can be found at myuhcvision.com.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.
Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.
In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.
Out-of-Network Provider - Participant pays full fee to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. All receipts must be submitted at the same time to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. Written proof of loss should be given to the Company within 90 days after the date of loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

Vision Benefit Card

UnitedHealthcare®

USF College of Medicine

Copays

Exam(s)	$10.00
Materials	$10.00

To print a personalized ID card, please log on to our website and select 'Group/Plan' then select 'Print ID card' from the member benefits page.

myuhcvision.com

Customer Service & Provider Locator: (800) 638-3120

TDD for Hearing Impaired: (877) 735-2929

UnitedHealthcare Insurance Company (30100)® Dental Plan
Voluntary Options PPO 20 / covered dental services New Standard/5P262/MAC

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum)	$1,000 per person per Calendar Year	$1,000 per person per Calendar Year	$1,000 per person per Lifetime	$1,000 per person per Lifetime
New enrollee's waiting period	None			
Annual deductible applies to preventive and diagnostic services			No (In Network)	No (Out Network)
Annual Deductible Applies to Orthodontic Services			No	
Orthodontic Eligibility Requirement			Adult & Child	

COVERED SERVICES *	**NETWORK PLAN PAYS****	**NON-NETWORK PLAN PAYS*****	**BENEFIT GUIDELINES**
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	See Exclusions and Limitations section for benefit guidelines.
Radiographs	100%	100%	
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Prophylaxis (Cleaning)	100%	100%	See Exclusions and Limitations section for benefit guidelines.
Fluoride Treatment (Preventive)	100%	100%	
Sealants	100%	100%	
Space Maintainers	100%	100%	
BASIC SERVICES			
Restorations (Amalgams or Composite)	80%	80%	See Exclusions and Limitations section for benefit guidelines.
Emergency Treatment/General Services	80%	80%	
Simple Extractions	80%	80%	
MAJOR SERVICES			
Oral Surgery (incl. surgical extractions)	50%	50%	See Exclusions and Limitations section for benefit guidelines.
Periodontics	50%	50%	
Endodontics	50%	50%	
Inlays/Onlays/Crowns	50%	50%	
Dentures and Removable Prosthetics	50%	50%	
Fixed Partial Dentures (Bridges)	50%	50%	
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	

* 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.

Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for Veneers, please refer to your Certificate of Coverage.

Cone Beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for Cone Beams, please refer to your Certificate of Coverage.

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/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 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; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

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.

GENERAL LIMITATIONS

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

2 COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.

3 BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

4 EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

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

6 FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

7 SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.

8 SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

9 RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.

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

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

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

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

14 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.

15 SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

16 ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

17 PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

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

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

20 RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

21 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.

22 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.

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

24 FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.

25 GENERAL ANESTHESIA Covered only when clinically necessary.

26 OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

27 PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.

28 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.

29 CONE BEAM Limited to 1 time per consecutive 60 months.

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 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 Dental 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 Placement of dental implants, implant-supported abutments and prostheses.

9 Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

10 Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

11 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.

12 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.

13 Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

14 Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

15 Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.

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 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 Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

20 Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

21 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. This exclusion does not apply for groups situsedin the state of Arizona, in order to comply with state regulations.

22 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.

23 Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

24 Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

25 Foreign Services are not Covered unless required as an Emergency.

26 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.

27 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

UnitedHealthcare Insurance Company (30100)®
Voluntary Options PPO 30 / covered dental services

Dental Plan
New Standard/5P263/U90

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum)	$1,500 per person per Calendar Year	$1,500 per person per Calendar Year	$1,500 per person per Lifetime	$1,500 per person per Lifetime
New enrollee's waiting period	None			
Annual deductible applies to preventive and diagnostic services			No (In Network)	No (Out Network)
Annual Deductible Applies to Orthodontic Services			No	
Orthodontic Eligibility Requirement			Adult & Child	

COVERED SERVICES *	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	See Exclusions and Limitations section for benefit guidelines.
Radiographs	100%	100%	
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Prophylaxis (Cleaning)	100%	100%	See Exclusions and Limitations section for benefit guidelines.
Fluoride Treatment (Preventive)	100%	100%	
Sealants	100%	100%	
Space Maintainers	100%	100%	
BASIC SERVICES			
Restorations (Amalgams or Composite)	80%	80%	See Exclusions and Limitations section for benefit guidelines.
Emergency Treatment/General Services	80%	80%	
Simple Extractions	80%	80%	
Oral Surgery (incl. surgical extractions)	80%	80%	
Periodontics	80%	80%	
Endodontics	80%	80%	
MAJOR SERVICES			
Inlays/Onlays/Crowns	50%	50%	See Exclusions and Limitations section for benefit guidelines.
Dentures and Removable Prosthetics	50%	50%	
Fixed Partial Dentures (Bridges)	50%	50%	
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	

* 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 non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for Veneers, please refer to your Certificate of Coverage.
Cone Beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for Cone Beams, please refer to your Certificate of Coverage.

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/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 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; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

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.

GENERAL LIMITATIONS

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

2 COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.

3 BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

4 EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

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

6 FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

7 SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.

8 SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

9 RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.

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

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

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

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

14 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.

15 SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

16 ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

17 PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

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

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

20 RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

21 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.

22 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.

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

24 FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.

25 GENERAL ANESTHESIA Covered only when clinically necessary.

26 OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

27 PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.

28 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.

29 CONE BEAM Limited to 1 time per consecutive 60 months.

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 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 Dental 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 Placement of dental implants, implant-supported abutments and prostheses.

9 Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

10 Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

11 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.

12 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.

13 Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

14 Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

15 Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.

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 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 Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

20 Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

21 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. This exclusion does not apply for groups situsedin the state of Arizona, in order to comply with state regulations.

22 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.

23 Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

24 Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

25 Foreign Services are not Covered unless required as an Emergency.

26 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.

27 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. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

Using your pharmacy benefit

UnitedHealthcare®

Your pharmacy benefit services

OptumRx® is your plan's pharmacy services manager and is committed to helping you find cost-effective ways to get your medication(s).

Set up your online account

Once registered on our website, access the pharmacy section by clicking "Manage My Prescriptions" to:

- Manage your home delivery medications.
- Set up email or text message[1] reminders.
- Check your order status.

Use the UnitedHealthcare® Health4Me® app

Manage your prescription benefit and home delivery orders with the **Health4Me** app on your smartphone or tablet.

Use a network pharmacy

Be sure to fill your prescriptions at a network pharmacy, otherwise they may not be covered or you may pay more. Finding a network pharmacy is easy:

- Log in to **myuhc.com®** then choose select **"**Manage My Prescriptions." Or, use the **Health4Me** app.
- Or call the number on the back of your health plan ID card.

Need more information? Visit **myuhc.com** to learn more.

Home delivery from OptumRx

Use OptumRx home delivery to help manage the medications you take regularly. Home delivery is safe, reliable and offers the following advantages:

Cost savings
You may pay less for your medication with a three-month supply through OptumRx.

Convenience
Get free standard shipping on medications delivered to your mailbox.

24/7 access and reminders
Speak to a pharmacist who can answer questions any time, any day. Even set up text and email reminders to help you remember to take or refill your medications.

Make the choice to use home delivery

By going online:
Visit **myuhc.com,** register and follow the simple step-by-step instructions.

By phone:
Call the member phone number on the back of your plan ID card. It's helpful to have your plan ID card and medication bottle available.

By ePrescribe:
Ask your doctor to send an electronic prescription.

If you need your medication right away, ask your doctor for a one-month prescription to fill at a local pharmacy and a three-month prescription you can use to set up home delivery.

Log on to **myuhc.com** see if you could save.
Or use the **Health4Me** app.

Making medication decisions

Use the UnitedHealthcare prescription drug list (PDL)

The PDL is a list of your plan's covered medications. The medications are organized into cost tiers. Choosing medications in lower tiers may save you money.

Cost tier	Includes	Helpful tips
$ **Tier 1** **Lowest cost**	Lower-cost medications. Some brand-name medications.	Tier 1 medications have the lowest out-of-pocket costs. Consider generic alternatives.
$$ **Tier 2** **Mid-range cost**	Mix of brand-name and generic medications.	Tier 2 drugs may cost less than Tier 3 drugs.
$$$ **Tier 3** **Highest cost**	Highest cost brand-name medications and some generic medications.	Many Tier 3 medications have lower-cost options in Tiers 1 or 2. Ask your doctor if they could work for you.

Save money

Generic medications usually have a lower co-pay than brand name medications. Ask your doctor if there is a generic alternative for you.

Compare prices

Search for lower-cost alternatives. Just log in to **myuhc.com,** click on "Manage My Prescriptions" and select "Drug Pricing." Or use the **Health4Me** app.

Need more information? Visit **myuhc.com** to learn more.

Tips

Know your plan

Your plan may require one or more of the following for your prescription to be covered:

Prior authorization — approval to get a medication.

Step therapy — trying one medication before another.

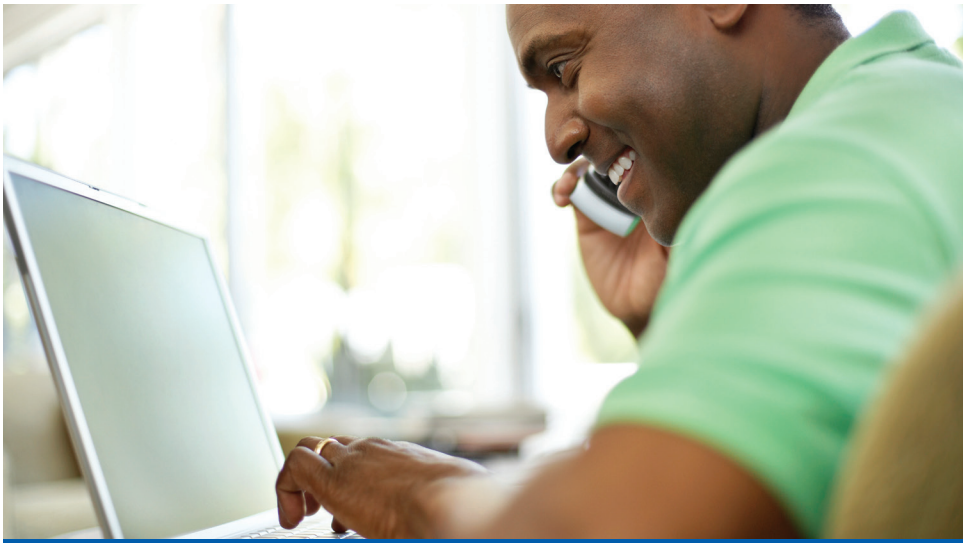
Quantity limits — only a certain amount of the medication is allowed for coverage.

Check your prescription drug list (PDL)

Your PDL is a list of covered medications. The list is broken into sections called tiers. Choosing medications in lower tiers may save you money. Check your PDL often.

Talk to your doctor

When you talk with your doctor, use the **Health4Me** app to confirm coverage and costs. You can also talk about what you need to do to get your medication.



Log on to **myuhc.com** see if you could save.
Or use the **Health4Me** app.

Your plan may also include

Mail Service Member Select

Your plan **may include** the cost-saving medication home delivery program below.

If your plan includes Mail Service Member Select, you are allowed a limited number of refills at your current pharmacy; then you must take action:

Program name	Action needed:
Mail Service Member Select	Choose to use OptumRx home delivery or stay at your retail pharmacy. If you choose to continue at your retail pharmacy, you must let OptumRx know your choice.

Hassle-Free℠ Fill

The Hassle-Free Fill program provides automatic refills for eligible maintenance medication if you use home delivery. When it's time to refill, OptumRx will automatically:

- Call to notify you that your medication will ship soon (unless you cancel it within three business days of the refill notice).
- Bill your credit card for any copay, coinsurance or amount due.

BriovaRx®, the OptumRx specialty pharmacy

You may be able to use BriovaRx, the OptumRx specialty pharmacy. BriovaRx is more than just a way for you to get your specialty medications. We provide ongoing support to help you manage more complicated conditions.

Need more information? Visit **myuhc.com** to learn more.

Log on to **myuhc.com** see if you could save.
Or use the **Health4Me** app.

Visit myuhc.com to get the most out of your pharmacy benefit.

UnitedHealthcare®

myuhc.com

1 OptumRx provides this service at no cost. Standard message and data rates charged by your carrier may apply.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health plan coverage provided by or through a UnitedHealthcare company. OptumRx, Inc. is an affiliate of UnitedHealthcare Insurance Company.

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