APPLICATION FOR DENTAL INSURANCE
UNITEDHEALTHCARE INSURANCE COMPANY
HARTFORD, CONNECTICUT 06103-0450

Applicant(s) Information

Gender	Name (Last, First, M.I.)	Birth Date
☐ Male ☐ Female	Primary (You)	____/____/_____
☐ Male ☐ Female	Spouse	____/____/_____

Permanent Home Address (PO Box/PMB is not allowed)

Street (Include Apt.)	City	State	ZIP Code

Mailing Address (if different from permanent home address)

Street (Include Apt.)	City	State	ZIP Code

Contact Information

Phone Number	Optional Email
( )	

Plan Selection

Plan Start Date
Your Plan will start on the first day of the month following receipt and approval of this Application Form and receipt of your first month's payment. If you would like your Plan to start on a later date (the first day of a future month), please indicate the date: ____/_01_/_____

Plans *(Choose One)*				
	☐ DVH 500	☐ DVH 1000	☐ DVH 2000	☐ DVH 3000
	☐ DVH 500 PLUS	☐ DVH 1000 PLUS	☐ DVH 2000 PLUS	☐ DVH 3000 PLUS

Initial Payment

Estimated Monthly Premium **$** _____

Statement of Understanding

I have read this application and represent that the information shown on it is true and complete. I understand and agree that:

(1) No insurance will become effective unless my application is approved and the appropriate premium is actually received by UnitedHealthcare Insurance Company (UHIC) with this application.

(2) The primary applicant must be age 64 and 11 months or older on the plan effective date to be eligible for coverage.

(3) Incorrect or incomplete information in this application may result in voidance of coverage and claim denial.

(4) The information provided in this application, and any supplement or amendments to it, will be made a part of any policy or policies that may be issued.

(5) If an application is approved, insurance will be effective:
   (a) The first day of the month following receipt and approval of this application and receipt of your first month's payment; or
   (b) The first day of a future month requested by you.

(6) The agent is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

(7) If UHIC rejects this application, under no circumstances will any benefits be payable. Receipt of payment by UHIC does not constitute approval of my application or create UHIC coverage.

(8) I have received a Notice of Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage.

(9) I have received an Outline of Coverage.

(10) I acknowledge that applicant has access to/has received a Guide to Health Insurance for People with Medicare. The Guide to Health Insurance for People with Medicare is available at: https://stage.uhone.com/api/supplysystem/?Filename=Medicare-Medigap-guide.pdf

(11) THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

Signature Information

	Signature	Date Signed
Primary Applicant		

IMPORTANT NOTICE TO PERSONS ON MEDICARE.
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

- Check the coverage in **all** health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

45574-X-10-0918

Producer Statement - Review the completed application before signing below.

Each question on the application was completed by the applicant(s). The applicant has received a Notice of Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage.

X _____ X _____

Signature of Licensed Producer | Print Full Name

Producer Number

Payment Method - Select one below.

☐ EFT – Complete EFT Authorization below

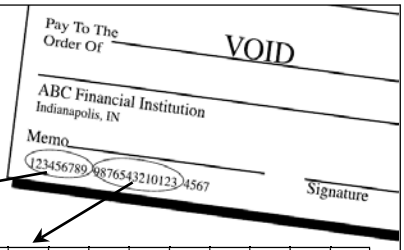
☐ Credit Card – Complete Credit Card Authorization below

Electronic Funds Transfer (EFT) and Credit Card payments will be collected at the time of application. Premium will be verified and may be adjusted up or down during the processing of your application.

☐ ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION – ONLY IF PAYING BY EFT:

I (we) hereby authorize UnitedHealthcare Insurance Company to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account.

I agree this authorization will remain in effect until you actually receive written notification of its termination from me.



Type of Account: ☐ Checking ☐ Savings

Nine-digit Routing No. _____ Account No. _____

Financial Institution's Name _____

Address _____

City, State, ZIP _____

Draft On _____ _____

Day | Date Signed

Only select a draft date between the 1st and 28th of the month.

In Tennessee and Texas, drafts may only be scheduled on 1) the premium due date; or 2) up to 10 days after the due date.

X _____

Authorized Account Signature

☐ CREDIT CARD AUTHORIZATION – ONLY IF PAYING BY CREDIT CARD:

I authorize UnitedHealthcare Insurance Company to bill my MasterCard/Visa/American Express/Discover account.

Type of Card: ☐MasterCard ☐Visa ☐American Express ☐Discover

Exp Date _____ _____

Month | Year

Billing ZIP Code: _____ Card Number: _____

X _____

Signature of Authorized User

Charge On _____

Day

Only select a charge date between the 1st and 28th of the month.

NOTE: Some card issuers/financial institutions charge cash advance fees on insurance payments.

UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103-0450
For Inquires: (800) 657-8205

In this outline, "you" or "your" will refer to the person for whom this outline has been prepared, and "we," "our," or "us" will refer to UnitedHealthcare Insurance Company.

Dental Coverage

Outline of Coverage for Policy Form DEN-P-UHC-10
(Please retain this outline for your records)

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

Read Your Policy Carefully – This outline sets forth a brief description of the important aspects of your policy. This is not the insurance contract. Only the actual policy will control. The policy sets forth in detail your and our rights and obligations. For this reason, it is important that you READ YOUR POLICY CAREFULLY!

Dental Coverage – Plans of this type are designed to provide the covered persons with coverage for dental care. The cost must be due to a covered dental service. Coverage is provided for preventive services. Coverage is subject to any coinsurance amounts or other limitations that may be set forth in the policy.

Dental Benefits

DENTAL BENEFITS: Benefits are limited to the dental services described below, per covered person, but only when each service is a covered expense. Benefits include services for telehealth and telemedicine services if those services would otherwise be covered expenses under the policy.

PREVENTIVE SERVICES

Cleanings:

A. Dental prophylaxis (cleanings), limited to 2 per calendar year (not covered on the same day as periodontal maintenance or full mouth debridement).

B. Periodontal maintenance, limited to 2 per calendar year, only covered when performed following active periodontal treatment.

Exams:

A. The following are limited to any 2 per calendar year (does not cover separate periodontal exams):

   1. Routine periodic oral evaluation completed during check up.

   2. Comprehensive oral evaluation for new or established patient.

B. Limited oral evaluation – problem focused.

C. Detailed and extensive oral evaluation – problem focused.

X-rays:

A. Intraoral - complete series of radiographic images, limited to 1 per 36 months. Vertical bitewings not allowed in conjunction with a complete series.

B. Intraoral periapical radiographic image.

C. Bitewings – single film, limited to 4 per calendar year (not covered in the same year as intraoral – complete series of radiographic images).

D. Bitewings – two films, limited to 2 per calendar year (not covered in the same year as intraoral – complete series of radiographic images).

E. The following are limited to 1 series per calendar year. Not covered in the same year as intraoral – complete series of radiographic images:

   1. Bitewings – three films.

   2. Bitewings – four films.

F. Vertical bitewings 7 to 8 radiographic images, limited to 1 per 36 months (not covered in the same year as intraoral – complete series of radiographic images).

G. Panoramic radiographic images, limited to 1 per 36 months.

Other Preventive:

A. Nutritional counseling, limited to 1 per calendar year.

B. Application of caries arresting medicament to a monosymptomatic carious tooth.

Amount Payable

We will pay the applicable coinsurance percentage in excess for the actual cost of services and supplies that qualify as covered expenses and are received while the covered person's coverage is in force under the policy.

The maximum benefit per covered person, per calendar year is shown in the policy Data Pages.

What Is Not Covered

No benefits will be paid for any service or treatment for which charges incurred are not identified and included as covered expenses under the policy. You will be fully responsible for payment for any services for which charges incurred are not covered expenses under the policy.

The policy does not pay benefits for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

A. Not a covered expense or for which no charge is made.

B. Provided prior to the effective date or after the termination date of the policy.

C. Fees/surcharges imposed on the covered person by a provider but that are actually the responsibility of the provider to pay.

D. In excess of the frequency limitations or maximum benefits as shown on the policy Data Pages.

E. Covered expenses which exceed the non-network provider reimbursement, as shown on the policy Data Pages.

F. Which no benefit is described in the policy or on the Data Page.

G. A dental service that is not rendered or that is not rendered within the scope of the dentist's license.

H. Telephone consultations or for failure to keep a scheduled appointment without giving the dental office 24 hour notice, or the notice required by the dental office in question.

I. Any service incurred directly or indirectly as a result of the covered person being intoxicated, as defined by applicable state law in the state in which the loss occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a doctor or voluntary taking of any over the counter drug unless taken in accordance with the manufacturer's recommended dosage.

J. Experimental or investigational treatment or for complications there from, including expenses that might otherwise be covered if they were not incurred in conjunction with, as a result of, or while receiving experimental or investigational treatment.

K. Which arise out of, or in the course of, employment for wage or profit, if the covered person is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law.

L. Intentionally self-inflicted bodily harm (whether the covered person is sane or insane), any act of declared or undeclared war, a covered person taking part in a riot, or a covered person's commission or attempt to commit a felony.

M. Provided by a government plan, program, hospital or other facility, unless by law a covered person must pay and it is otherwise a covered expense or which by law must be provided by an educational institution.

N. Provided without cost to a covered person in the absence of insurance covering the charge.

O. Provided by an immediate family member or someone who ordinarily resides with a covered person.

P. Received outside of the United States.

Q. 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.

R. Teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism,

abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis as determined by us.

S. Performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance such as internal/external bleaching, veneers.)

T. Mouthguards; precision or semi-precision attachments; duplicate dentures; harmful habit appliances; occlusal guard except if expressly provided in the policy; replacement of lost or stolen appliances; treatment splints; bruxism appliance; sleep disorder appliance.

U. Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies including but not limited to take-home fluoride; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures.

V. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the covered person's dental visit.

W. Hospital or other facility charges and related anesthesia charges.

X. Charges for dental services that are not documented in the dentist records, that are not directly associated with dental disease, or that are not performed in a dental setting.

Y. Two or more dental services are submitted and the dental services are considered part of the same dental service to one another, we will pay the most comprehensive dental service.

Z. Two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one dental service contradicts the need for the other dental service), we will pay for the dental service that represents the final treatment.

Term of Coverage and Renewability

The policy term begins as of the effective date of the policy. You may keep the policy in force by paying us the required premium as it comes due. However, we may cancel the policy if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim.

Premium

At any policy anniversary date, we may change the rate table used for the policy form. Each premium will be based on the rate table in effect on that premium's due date. The type and level of benefits and place of residence on the premium due date are some of the factors that could be used in determining your premium rates. At least 60-days written notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under the policy or a change in a covered person's health.

UnitedHealthcare Insurance Company
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Dental Coverage

Outline of Coverage for Policy Form DEN-PBM-UHC-10
(Please retain this outline for your records)

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

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Dental Coverage – Plans of this type are designed to provide the covered persons with coverage for dental care. The cost must be due to a covered dental service. Coverage is provided for preventive, basic, and major services. Coverage is subject to any coinsurance amounts or other limitations that may be set forth in the policy.

Dental Benefits

DENTAL BENEFITS: Benefits are limited to the dental services described below, per covered person, but only when each service is a covered expense. Benefits include services for telehealth and telemedicine services if those services would otherwise be covered expenses under the policy.

PREVENTIVE SERVICES

Cleanings:

A. Dental prophylaxis (cleanings), limited to 2 per calendar year (not covered on the same day as periodontal maintenance or full mouth debridement).

B. Periodontal maintenance, limited to 2 per calendar year, only covered when performed following active periodontal treatment.

Exams:

A. The following are limited to any 2 per calendar year (does not cover separate periodontal exams):

   1. Routine periodic oral evaluation completed during check up.

   2. Comprehensive oral evaluation for new or established patient.

B. Limited oral evaluation – problem focused.

C. Detailed and extensive oral evaluation – problem focused.

X-rays:

A. Intraoral - complete series of radiographic images, limited to 1 per 36 months. Vertical bitewings not allowed in conjunction with a complete series.

B. Intraoral periapical radiographic image.

C. Bitewings – single film, limited to 4 per calendar year (not covered in the same year as intraoral – complete series of radiographic images).

D. Bitewings – two films, limited to 2 per calendar year (not covered in the same year as intraoral – complete series of radiographic images).

E. The following are limited to 1 series per calendar year (not covered in the same year as intraoral – complete series of radiographic images):

   1. Bitewings – three films.

   2. Bitewings – four films.

F. Vertical bitewings 7 to 8 radiographic images, limited to 1 per 36 months (not covered in the same year as intraoral – complete series of radiographic images).

G. Panoramic radiographic images, limited to 1 per 36 months.

Other Preventive:

A. Nutritional counseling, limited to 1 per calendar year.

B. Application of caries arresting medicament to a monosymptomatic carious tooth.

BASIC SERVICES

Amalgam Restorations (Silver Fillings):

A. Amalgam - one surface, primary or permanent.

B. Amalgam - two surfaces, primary or permanent.

C. Amalgam - three surfaces, primary or permanent.

D. Amalgam - four or more surfaces, primary or permanent.

Composite Resin Restorations (Tooth Colored Fillings):

A. Resin-based composite – one surface, anterior; two surfaces, anterior; three surfaces, anterior; four or more surfaces or involving incisal angle, anterior.

B. Resin-based composite – one surface, posterior; two surfaces, posterior; three surfaces, posterior; four or more surfaces, posterior.

Other Basic Services:

A. Protective restorations.

B. Pulp caps – direct / indirect (excluding final restoration), does not cover bases and liners when all caries has been removed.

C. Evaluation for deep sedation or general anesthesia.

D. Deep sedation/general anesthesia – first 15 minutes and each subsequent 15 minutes.

E. Nitrous oxide inhalation.

F. Intravenous moderate (conscious) sedation/analgesia – first 15 minutes and each subsequent 15 minutes.

MAJOR SERVICES

Bridges:

A. Pontics, limited to 1 per 60 months.

B. Retainer crowns, limited to 1 per 60 months.

C. Re-cement or re-bond bridge fixed partial denture, limited to those performed more than 12 months after initial insertion.

Crowns, Inlays, Onlays:

A. The following are limited to 1 per tooth per 60 months. Covered only when a filling cannot restore the tooth and does not cover crowns for cosmetic reasons or for closing gaps.

1. Inlay – metallic – one surface; two surfaces; three or more surfaces.

2. Onlay – metallic – two surfaces; three surfaces; four or more surfaces.

3. Inlay – porcelain/ceramic – one surface; two surfaces; three or more surfaces.

4. Onlay – porcelain/ceramic – two surfaces; three surfaces; four or more surfaces.

5. Crown – porcelain/ceramic substrate; porcelain fused to high noble metal; porcelain fuse to predominantly base metal; porcelain fused to noble metal; full cast high noble metal; full cast predominantly base metal; full cast noble metal; titanium and titanium alloys.

B. Re-cement crown that has fallen off.

C. Restorative foundation for an indirect restoration, when performed together with a crown.

D. Core buildup, including any pings, when performed together with a crown.

E. The following are limited to either indirectly fabricated or prefabricated and are only covered for teeth that have had a root canal therapy and when performed together with a crown:

1. Post and core in addition to crown indirectly fabricated and each additional indirectly fabricated post – same tooth; or

2. Prefabricated post and core in addition to crown and each additional prefabricated post – same tooth.

Endodontics:

A. Anterior, bicuspid, or molar root canal (excluding final restoration), limited to 1 per tooth per lifetime.

B. Retreatment of previous root canal therapy – anterior, bicuspid, and molar.

Extractions and Oral Surgery:

A. The following are limited to 1 per tooth per lifetime (covered only on erupted permanent teeth):

   1. Extraction coronal remnants, primary tooth.
   2. Extraction, erupted tooth or exposed root (elevation and/or forceps removal).
   3. Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of the tooth.
   4. Surgical removal of residual tooth roots.

B. Incision and drainage of abscess – intraoral soft tissue.

C. Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces).

Other Major Services:

A. Palliative (emergency) treatment of dental pain – minor procedure.

B. TMD (commonly known as TMJ-Temporomandibular Joint/ Temporomandibular Disorder):

   1. Temporomandibular joint diagnostics, limited to 1 film per joint, 2 films per calendar year.
   2. Tomographic survey, limited to 1 film per joint per calendar year.
   3. Manipulation under anesthesia, limited to 1 per visit.
   4. Occlusal orthotic device, limited to 1 per 24 months.
   5. Occlusal guard relining and repairing, limited to 1 timer per 12 months and limited to relining/repairing perform more than 5 months after the initial insertion.

Periodontics:

A. Periodontal scaling and root planning – four or more teeth per quadrant; one to three teeth per quadrant; limited to 1 per quadrant every 24 months, not to exceed four unique quadrants every 24 months.

B. Full mouth debridement to enable comprehensive evaluation and diagnosis, limited to 1 per 36 months.

C. Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, cannot be used the same day as scaling or root planing.

We will provide benefits for services provided by a dentist through telemedicine if the charges would otherwise be considered covered expenses under this policy.

Amount Payable

We will pay the applicable coinsurance percentage in excess for the actual cost of services and supplies that qualify as covered expenses and are received while the covered person's coverage is in force under the policy.

The maximum benefit per covered person, per calendar year is shown in the policy Data Pages.

What Is Not Covered

No benefits will be paid for any service or treatment for which charges incurred are not identified and included as covered expenses under the policy. You will be fully responsible for payment for any services for which charges incurred are not covered expenses under the policy.

The policy does not pay benefits for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

A. Not a covered expense or for which no charge is made.

B. Provided prior to the effective date or after the termination date of the policy.

C. Fees/surcharges imposed on the covered person by a provider but that are actually the responsibility of the provider to pay.

D. In excess of the frequency limitations or maximum benefits as shown on the policy Data Pages.

E. Covered expenses which exceed the non-network provider reimbursement, as shown on the policy Data Pages.

F. Which no benefit is described in the policy or on the Data Page.

G. A dental service that is not rendered or that is not rendered within the scope of the dentist's license.

H. Veneers, implant crowns, and ¾ crowns.

I. Replacement of bridges, crowns, or onlay which can be repaired or restored to natural function.

J. Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service.

K. Telephone consultations or for failure to keep a scheduled appointment without giving the dental office 24 hour notice, or the notice required by the dental office in question.

L. Any service incurred directly or indirectly as a result of the covered person being intoxicated, as defined by applicable state law in the state in which the loss occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a doctor or voluntary taking of any over the counter drug unless taken in accordance with the manufacturer's recommended dosage.

M. Experimental or investigational treatment or for complications there from, including expenses that might otherwise be covered if they were not incurred in conjunction with, as a result of, or while receiving experimental or investigational treatment.

N. Which arise out of, or in the course of, employment for wage or profit, if the covered person is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law.

O. Intentionally self-inflicted bodily harm (whether the covered person is sane or insane), any act of declared or undeclared war, a covered person taking part in a riot, or a covered person's commission or attempt to commit a felony.

P. Provided by a government plan, program, hospital or other facility, unless by law a covered person must pay and it is otherwise a covered expense or which by law must be provided by an educational institution.

Q. Provided without cost to a covered person in the absence of insurance covering the charge.

R. Provided by an immediate family member or someone who ordinarily resides with a covered person.

S. Received outside of the United States, except for a dental emergency.

T. 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, except as expressly provided in the policy.

U. Teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis as determined by us.

V. Performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance such as internal/external bleaching, veneers.)

W. 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.

X. Changing vertical dimension; restoring occlusion; bite analysis, congenital malformation.

Y. Orthognathic surgery.

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

AA. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal.

BB. Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.

CC. Mouthguards; precision or semi-precision attachments; duplicate dentures; harmful habit appliances; occlusal guard except if expressly provided in the policy; replacement of lost or stolen appliances; treatment splints; bruxism appliance; sleep disorder appliance.

DD. Oral hygiene instructions; plaque control;

EE. charges for completing dental claim forms; photographs; any dental supplies including but not limited to take-home fluoride; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures.

FF. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the covered person's dental visit.

GG. Replacement of 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 the covered person's non-compliance, the covered person is liable for the cost of the replacement.

HH. Hospital or other facility charges and related anesthesia charges.

II. Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis.

JJ. Altering vertical dimension and/or restoring or maintaining occlusion. Such procedures include, but are not limited to, equilibrium, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

KK. Non-intravenous conscious sedation, analgesia, anxiolysis, inhalation of nitrous oxide and conscious sedation, unless expressly provided for in the policy.

LL. Charges for dental services that are not documented in the dentist records, that are not directly associated with dental disease, or that are not performed in a dental setting.

MM. Orthodontic services.

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

NN. Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations).

OO. Two or more dental services are submitted and the dental services are considered part of the same dental service to one another, we will pay the most comprehensive dental service.

PP. Two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one dental service contradicts the need for the other dental service), we will pay for the dental service that represents the final treatment.

QQ. Surgical extractions of wisdom teeth.

Term of Coverage and Renewability

The policy term begins as of the effective date of the policy. You may keep the policy in force by paying us the required premium as it comes due. However, we may cancel the policy if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim.

Premium

At any policy anniversary date, we may change the rate table used for the policy form. Each premium will be based on the rate table in effect on that premium's due date. The type and level of benefits and place of residence on the premium due date are some of the factors that could be used in determining your premium rates. At least 60-days written notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under the policy or a change in a covered person's health.

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For Inquires: (800) 657-8205

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Dental Coverage

Outline of Coverage for Policy Form DEN-PBMD-UHC-10
(Please retain this outline for your records)

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Dental Benefits

DENTAL BENEFITS: Benefits are limited to the dental services described below, per covered person, but only when each service is a covered expense. Benefits include services for telehealth and telemedicine services if those services would otherwise be covered expenses under the policy.

PREVENTIVE SERVICES

Cleanings:

A. Dental prophylaxis (cleanings), limited to 2 per calendar year (not covered on the same day as periodontal maintenance or full mouth debridement).

B. Periodontal maintenance, limited to 2 per calendar year, only covered when performed following active periodontal treatment.

Exams:

A. The following are limited to any 2 per calendar year (does not cover a separate periodontal exam):

   1. Routine periodic oral evaluation completed during check up.

   2. Comprehensive oral evaluation for new or established patient.

B. Limited oral evaluation – problem focused.

C. Detailed and extensive oral evaluation – problem focused.

X-rays:

A. Intraoral - complete series of radiographic images, limited to 1 per 36 months. Vertical bitewings not allowed in conjunction with a complete series.

B. Intraoral periapical radiographic image.

C. Bitewings – single film, limited to 4 per calendar year (not covered in the same year as intraoral – complete series of radiographic images).

D. Bitewings – two films, limited to 2 per calendar year (not covered in the same year as intraoral – complete series of radiographic images).

E. The following are limited to 1 series per calendar year (not covered in the same year as intraoral – complete series of radiographic images):

   1. Bitewings – three films.

   2. Bitewings – four films.

F. Vertical bitewings 7 to 8 radiographic images, limited to 1 per 36 months (not covered in the same year as intraoral – complete series of radiographic images).

G. Panoramic radiographic images, limited to 1 per 36 months.

Other Preventive:

A. Nutritional counseling, limited to 1 per calendar year.

B. Application of caries arresting medicament to a monosymptomatic carious tooth.

BASIC SERVICES

Amalgam Restorations (Silver Fillings):

A. Amalgam - one surface, primary or permanent.

B. Amalgam - two surfaces, primary or permanent.

C. Amalgam - three surfaces, primary or permanent.

D. Amalgam - four or more surfaces, primary or permanent.

Composite Resin Restorations (Tooth Colored Fillings):

A. Resin-based composite – one surface, anterior; two surfaces, anterior; three surfaces, anterior; four or more surfaces or involving incisal angle, anterior.

B. Resin-based composite – one surface, posterior; two surfaces, posterior; three surfaces, posterior; four or more surfaces, posterior.

Other Basic Services:

A. Protective restorations.

B. Pulp caps – direct/indirect (excluding final restoration), does not cover bases and liners when all caries has been removed.

C. Evaluation for deep sedation or general anesthesia.

D. Deep sedation/general anesthesia – first 15 minutes and each subsequent 15 minutes.

E. Nitrous oxide inhalation.

F. Intravenous moderate (conscious) sedation/analgesia – first 15 minutes and each subsequent 15 minutes.

MAJOR SERVICES

Bridges:

A. Pontics, limited to 1 per 60 months.

B. Retainer crowns, limited to 1 per 60 months.

C. Re-cement or re-bond bridge fixed partial denture, limited to those performed more than 12 months after the initial insertion.

Crowns, Inlays, Onlays:

A. The following are limited to 1 per tooth per 60 months. Covered only when a filling cannot restore the tooth and does not cover crowns for cosmetic reasons or for closing gaps.

1. Inlay – metallic – one surface; two surfaces; three or more surfaces.

2. Onlay – metallic – two surfaces; three surfaces; four or more surfaces.

3. Inlay – porcelain/ceramic – one surface; two surfaces; three or more surfaces.

4. Onlay – porcelain/ceramic – two surfaces; three surfaces; four or more surfaces.

5. Crown – porcelain/ceramic substrate; porcelain fused to high noble metal; porcelain fuse to predominantly base metal; porcelain fused to noble metal; full cast high noble metal; full cast predominantly base metal; full cast noble metal; titanium and titanium alloys.

B. Re-cement crown that has fallen off.

C. Restorative foundation for an indirect restoration, when performed together with a crown.

D. Core buildup, including any pings, when performed together with a crown.

E. The following are limited to either indirectly fabricated or prefabricated and are only covered for teeth that have had a root canal therapy and when performed together with a crown:

1. Post and core in addition to crown indirectly fabricated and each additional indirectly fabricated post – same tooth; or

2. Prefabricated post and core in addition to crown and each additional prefabricated post – same tooth.

Dentures:

A. Complete denture – maxillary/mandibular, limited to 1 per 60 months. Covered when there are no erupted teeth remaining in the mouth.

B. Immediate denture – maxillary/mandibular, limited to 1 per 60 months. Covered when there are no erupted teeth remaining in the mouth.

C. The following are limited to 1 per 60 months, includes retentive/clasping materials, rests, and teeth. Covered when remaining/supporting teeth are free of cavities and have good bone to support partial denture:

1. Mandibular partial denture – resin based; cast metal framework with resin denture bases; flexible base.
2. Maxillary partial denture – resin based; cast metal framework with resin denture bases; flexible base.
3. Immediate mandibular/maxillary partial denture – resin base.

D. Tissue conditioning – maxillary/mandibular, limited to 1 per 12 months.

E. The following are limited to 1 per denture per 6 months (must be performed more than 6 months after initial insertion):

1. Adjust complete or partial denture – maxillary/mandibular.
2. Repair broken complete denture base – mandibular/maxillary.
3. Repair resin partial denture base – mandibular/maxillary.
4. Replace missing or broken teeth – complete denture.
5. Repair cast partial framework – mandibular/maxillary.
6. Repair or replace broken retentive/clasping materials, per tooth.
7. Replace broken teeth, per tooth.
8. Add tooth to existing partial denture.
9. Add clasp to existing partial denture.

F. The following are limited to 1 per denture per 12 months (must be performed more than 6 months after initial insertion):

1. Reline complete mandibular/maxillary denture – direct.
2. Reline complete mandibular/maxillary denture – indirect.
3. Reline mandibular/maxillary partial denture – direct.
4. Reline mandibular/maxillary partial denture – indirect.

Endodontics:

A. Anterior, bicuspid, and molar root canal (excluding final restoration), limited to 1 per tooth per lifetime.

B. Retreatment of previous root canal therapy – anterior, bicuspid, and molar.

Extractions and Oral Surgery:

A. The following are limited to 1 per tooth per lifetime (covered only on erupted permanent teeth):

1. Extraction coronal remnants, primary tooth
2. Extraction, erupted tooth or exposed root (elevation and/or forceps removal).
3. Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of the tooth.
4. Surgical removal of residual tooth roots.

B. Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces; one to three teeth or tooth spaces.

C. Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces; one to three teeth or tooth spaces.

D. Incision and drainage of abscess – intraoral soft tissue.

E. Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces).

Other Major Services:

A. Palliative (emergency) treatment of dental pain – minor procedure.

B. Application of desensitizing medicament.

C. Occlusal orthotic device, by report, for treatment of temporomandibular joint (TMJ) dysfunction, limited to 1 per 36 months.

D. Occlusal guard – hard appliance, full arch, limited to one per 36 months. Only covered in association with documented tooth clenching or grinding. Does not cover any type of sleep

apnea, snoring or temporomandibular joint disorder (TMD) appliances.

E. Adjustment of occlusal guard, limited to 1 per 6 months (not covered within 6 months of occlusal guard delivery).

F. TMD (commonly known as TMJ-Temporomandibular Joint/ Temporomandibular Disorder):

1. Temporomandibular joint diagnostics, limited to 1 film per joint, 2 films per calendar year.
2. Tomographic survey, limited to 1 film per joint per calendar year.
3. Manipulation under anesthesia, limited to 1 per visit.
4. Occlusal orthotic device, limited to 1 per 24 months.
5. Occlusal guard relining and repairing, limited to 1 timer per 12 months and limited to relining/repairing perform more than 5 months after the initial insertion.

Periodontics:

A. Periodontal scaling and root planning – four or more teeth per quadrant; one to three teeth per quadrant; limited to 1 per quadrant every 24 months, not to exceed four unique quadrants every 24 months.

B. Full mouth debridement to enable comprehensive evaluation and diagnosis, limited to 1 per 36 months.

C. Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, cannot be used the same day as scaling or root planing.

We will provide benefits for services provided by a dentist through telemedicine if the charges would otherwise be considered covered expenses under this policy.

Amount Payable

We will pay the applicable coinsurance percentage in excess for the actual cost of services and supplies that qualify as covered expenses and are received while the covered person's coverage is in force under the policy.

The maximum benefit per covered person, per calendar year is shown in the policy Data Pages.

What Is Not Covered

No benefits will be paid for any service or treatment for which charges incurred are not identified and included as covered expenses under the policy. You will be fully responsible for payment for any services for which charges incurred are not covered expenses under the policy.

The policy does not pay benefits for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

A. Not a covered expense or for which no charge is made.

B. Provided prior to the effective date or after the termination date of the policy.

C. Fees/surcharges imposed on the covered person by a provider but that are actually the responsibility of the provider to pay.

D. In excess of the frequency limitations or maximum benefits as shown on the policy Data Pages.

E. Covered expenses which exceed the non-network provider reimbursement, as shown on the policy Data Pages.

F. Which no benefit is described in the policy or on the Data Page.

G. A dental service that is not rendered or that is not rendered within the scope of the dentist's license.

H. Veneers, implant crowns, and ¾ crowns.

I. Replacement within 60 consecutive months of the last placement for full and partial dentures.

J. Replacement of complete dentures, fixed and removable partial dentures, 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 the covered persons non-compliance, the covered person is liable for the cost of the replacement.

K. Replacement of full or partial removable dentures, bridges, crowns, or onlay which can be repaired or restored to natural function.

L. Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service.

M. Telephone consultations or for failure to keep a scheduled appointment without giving the dental office 24 hour notice or the notice required by the dental office in question.

N. Any service incurred directly or indirectly as a result of the covered person being intoxicated, as defined by applicable state law in the state in which the loss occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a doctor or voluntary taking of any over the counter drug unless taken in accordance with the manufacturer's recommended dosage.

O. Experimental or investigational treatment or for complications there from, including expenses that might otherwise be covered if they were not incurred in conjunction with, as a result of, or while receiving experimental or investigational treatment.

P. Which arise out of, or in the course of, employment for wage or profit, if the covered person is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law.

Q. Intentionally self-inflicted bodily harm (whether the covered person is sane or insane), any act of declared or undeclared war, a covered person taking part in a riot, or a covered person's commission or attempt to commit a felony.

R. Provided by a government plan, program, hospital or other facility, unless by law a covered person must pay and it is otherwise a covered expense or which by law must be provided by an educational institution.

S. Provided without cost to a covered person in the absence of insurance covering the charge.

T. Provided by an immediate family member or someone who ordinarily resides with a covered person.

U. Received outside of the United States, except for a dental emergency.

V. 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, except as expressly provided in the policy.

W. Teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis as determined by us.

X. Performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance such as internal/external bleaching, veneers.)

Y. 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.

Z. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

AA. Changing vertical dimension; restoring occlusion; bite analysis, congenital malformation.

BB. Orthognathic surgery.

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

DD. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal.

EE. Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.

FF. Mouthguards; precision or semi-precision attachments; duplicate dentures; harmful habit appliances; occlusal guard except if expressly provided in the policy; replacement of lost or stolen appliances; treatment splints; bruxism appliance; sleep disorder appliance.

GG. Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies including but not limited to take-home fluoride;

sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures.

HH. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the covered person's dental visit.

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

JJ. Replacement of 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 the covered person's non-compliance, the covered person is liable for the cost of the replacement.

KK. Hospital or other facility charges and related anesthesia charges.

LL. Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis.

MM. Altering vertical dimension and/or restoring or maintaining occlusion. Such procedures include, but are not limited to, equilibrium, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

NN. Non-intravenous conscious sedation, analgesia, anxiolysis, inhalation of nitrous oxide and conscious sedation, unless expressly provided for in the policy.

OO. Charges for dental services that are not documented in the dentist records, that are not directly associated with dental disease, or that are not performed in a dental setting.

PP. Orthodontic services.

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

RR. Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations).

SS. Two or more dental services are submitted and the dental services are considered part of the same dental service to one another, we will pay the most comprehensive dental service.

TT. Two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one dental service contradicts the need for the other dental service), we will pay for the dental service that represents the final treatment.

UU. Surgical extractions of wisdom teeth.

Term of Coverage and Renewability

The policy term begins as of the effective date of the policy. You may keep the policy in force by paying us the required premium as it comes due. However, we may cancel the policy if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim.

Premium

At any policy anniversary date, we may change the rate table used for the policy form. Each premium will be based on the rate table in effect on that premium's due date. The type and level of benefits and place of residence on the premium due date are some of the factors that could be used in determining your premium rates. At least 60-days written notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under the policy or a change in a covered person's health.

UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103-0450
For Inquires: (800) 657-8205

In this outline, "you" or "your" will refer to the person for whom this outline has been prepared, and "we," "our," or "us" will refer to UnitedHealthcare Insurance Company.

Dental Coverage

Outline of Coverage for Policy Form DEN-PBMI-UHC-10
(Please retain this outline for your records)

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

Read Your Policy Carefully – This outline sets forth a brief description of the important aspects of your policy. This is not the insurance contract. Only the actual policy will control. The policy sets forth in detail your and our rights and obligations. For this reason, it is important that you READ YOUR POLICY CAREFULLY!

Dental Coverage – Plans of this type are designed to provide the covered persons with coverage for dental care. The cost must be due to a covered dental service. Coverage is provided for preventive, basic, and major services including dentures and implants. Coverage is subject to any coinsurance amounts or other limitations that may be set forth in the policy.

Dental Benefits

DENTAL BENEFITS: Benefits are limited to the dental services described below, per covered person, but only when each service is a covered expense. Benefits include services for telehealth and telemedicine services if those services would otherwise be covered expenses under the policy.

PREVENTIVE SERVICES

Cleanings:

A. Dental prophylaxis (cleanings), limited to 2 per calendar year (not covered on the same day as periodontal maintenance or full mouth debridement).

B. Periodontal maintenance, limited to 2 per calendar year, only covered when performed following active periodontal treatment.

Exams:

A. The following are limited to any 2 per calendar year (does not cover separate periodontal exams):

   1. Routine periodic oral evaluation completed during check up.

   2. Comprehensive oral evaluation for new or established patient.

B. Limited oral evaluation – problem focused.

C. Detailed and extensive oral evaluation – problem focused.

X-rays:

A. Intraoral - complete series of radiographic images, limited to 1 per 36 months. Vertical bitewings not allowed in conjunction with a complete series.

B. Intraoral periapical radiographic image.

C. Bitewings – single film, limited to 4 per calendar year (not covered in the same year as intraoral – complete series of radiographic images).

D. Bitewings – two films, limited to 2 per calendar year (not covered in the same year as intraoral – complete series of radiographic images).

E. The following are limited to 1 series per calendar year (not covered in the same year as intraoral – complete series of radiographic images):

   1. Bitewings – three films.

   2. Bitewings – four films.

F. Vertical bitewings 7 to 8 radiographic images, limited to 1 per 36 months (not covered in the same year as intraoral – complete series of radiographic images).

G. Panoramic radiographic images, limited to 1 per 36 months.

Other Preventive:

A. Nutritional counseling, limited to 1 per calendar year.

B. Application of caries arresting medicament to a monosymptomatic carious tooth.

BASIC SERVICES

Amalgam Restorations (Silver Fillings):

A. Amalgam - one surface, primary or permanent.

B. Amalgam - two surfaces, primary or permanent.

C. Amalgam - three surfaces, primary or permanent.

D. Amalgam - four or more surfaces, primary or permanent.

Composite Resin Restorations (Tooth Colored Fillings):

A. Resin-based composite – one surface, anterior; two surfaces, anterior; three surfaces, anterior; four or more surfaces or involving incisal angle, anterior.

B. Resin-based composite – one surface, posterior; two surfaces, posterior; three surfaces, posterior; four or more surfaces, posterior.

Other Basic Services:

A. Protective restorations.

B. Pulp caps – direct/indirect (excluding final restoration), does not cover bases and liners when all caries has been removed.

C. Evaluation for deep sedation or general anesthesia.

D. Deep sedation/general anesthesia – first 15 minutes and each subsequent 15 minutes.

E. Nitrous oxide inhalation.

F. Intravenous moderate (conscious) sedation/analgesia – first 15 minutes and each subsequent 15 minutes.

MAJOR SERVICES

Bridges:

A. Pontics, limited to 1 per 60 months.

B. Retainer crowns, limited to 1 per 60 months.

C. Re-cement or re-bond bridge fixed partial denture, limited to those performed more than 12 months after the initial insertion..

Crowns, Inlays, Onlays:

A. The following are limited to 1 per tooth per 60 months. Covered only when a filling cannot restore the tooth and does not cover crowns for cosmetic reasons or for closing gaps.

1. Inlay – metallic – one surface; two surfaces; three or more surfaces.

2. Onlay – metallic – two surfaces; three surfaces; four or more surfaces.

3. Inlay – porcelain/ceramic – one surface; two surfaces; three or more surfaces.

4. Onlay – porcelain/ceramic – two surfaces; three surfaces; four or more surfaces.

5. Crown – porcelain/ceramic substrate; porcelain fused to high noble metal; porcelain fuse to predominantly base metal; porcelain fused to noble metal; full cast high noble metal; full cast predominantly base metal; full cast noble metal; titanium and titanium alloys.

B. Re-cement crown that has fallen off.

C. Restorative foundation for an indirect restoration, when performed together with a crown.

D. Core buildup, including any pings, when performed together with a crown.

E. The following are limited to either indirectly fabricated or prefabricated and are only covered for teeth that have had a root canal therapy and when performed together with a crown:

1. Post and core in addition to crown indirectly fabricated and each additional indirectly fabricated post – same tooth; or

2. Prefabricated post and core in addition to crown and each additional prefabricated post – same tooth.

Dentures:

A. Complete denture – maxillary/mandibular, limited to 1 per 60 months. Covered when there are no erupted teeth remaining in the mouth.

B. Immediate denture – maxillary/mandibular, limited to 1 per 60 months. Covered when there are no erupted teeth remaining in the mouth.

C. The following are limited to 1 per 60 months, includes retentive/clasping materials, rests, and teeth. Covered when remaining/supporting teeth are free of cavities and have good bone to support partial denture:

   1. Mandibular partial denture – resin based; cast metal framework with resin denture bases; flexible base.
   2. Maxillary partial denture – resin based; cast metal framework with resin denture bases; flexible base.
   3. Immediate mandibular/maxillary partial denture – resin base.

D. Tissue conditioning – maxillary/mandibular, limited to 1 per 12 months.

E. The following are limited to 1 per denture per 6 months (must be performed more than 6 months after initial insertion):

   1. Adjust complete or partial denture – maxillary/mandibular.
   2. Repair resin partial denture base – mandibular/maxillary.
   3. Replace missing or broken teeth – complete denture.
   4. Repair cast partial framework – mandibular/maxillary.
   5. Repair or replace broken retentive/ clasping materials, per tooth.
   6. Replace broken teeth, per tooth.
   7. Add tooth to existing partial denture.
   8. Add clasp to existing partial denture.

F. The following are limited to 1 per denture per 12 months (must be performed more than 6 months after initial insertion):

   1. Reline complete mandibular/maxillary denture – direct.
   2. Reline complete mandibular/maxillary denture – indirect.
   3. Reline mandibular/maxillary partial denture – direct.
   4. Reline mandibular/maxillary partial denture – indirect

Endodontics Services:

A. Anterior, bicuspid, and molar root canal (excluding final restoration), limited to 1 per tooth per lifetime.

B. Retreatment of previous root canal therapy – anterior, bicuspid, and molar.

Extractions and Oral Surgery:

A. The following are limited to 1 per tooth per lifetime (covered only on erupted permanent teeth):

   1. Extraction coronal remnants, primary tooth
   2. Extraction, erupted tooth or exposed root (elevation and/or forceps removal).
   3. Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of the tooth.
   4. Surgical removal of residual tooth roots.

B. Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces; one to three teeth or tooth spaces.

C. Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces; one to three teeth or tooth spaces.

D. Incision and drainage of abscess – intraoral soft tissue.

E. Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces).

Implants

Benefits are limited to the following per covered person, after the waiting period as shown on the Data Page, has been satisfied:

A. Implant placement, limited to 1 time per tooth per 60 months.

B. Implant supported prosthetics, limited to 1 time per tooth per 60 months.

C. Implant maintenance procedures, includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of

prosthesis, limited to 1 per tooth per 60 months.

D. Repair implant supported prosthesis, limited to 1 time per tooth per 60 months.

E. Abutment supported crown (titanium) or retainer crown or FPD – titanium, limited to 1 time per tooth per 60 months.

F. Repair implant abutment by support, limited to 1 time per tooth per 60 months.

G. Radiographical/surgical implant index by report, limited to 1 time per tooth per 60 months.

Other Major Services:

A. Palliative (emergency) treatment of dental pain – minor procedure.

B. Application of desensitizing medicament.

C. Occlusal orthotic device, by report, for treatment of temporomandibular joint (TMJ) dysfunction, limited to 1 per 36 months.

D. Occlusal guard – hard appliance, full arch, limited to one per 36 months. Only covered in association with documented tooth clenching or grinding. Does not cover any type of sleep apnea, snoring or temporomandibular joint disorder (TMD) appliances.

E. Adjustment of occlusal guard, limited to 1 per 6 months (not covered within 6 months of occlusal guard delivery).

F. TMD (commonly known as TMJ-Temporomandibular Joint/ Temporomandibular Disorder):

1. Temporomandibular joint diagnostics, limited to 1 film per joint, 2 films per calendar year.
2. Tomographic survey, limited to 1 film per joint per calendar year.
3. Manipulation under anesthesia, limited to 1 per visit.
4. Occlusal orthotic device, limited to 1 per 24 months.
5. Occlusal guard relining and repairing, limited to 1 timer per 12 months and limited to relining/repairing perform more than 5 months after the initial insertion.

Periodontics:

A. Periodontal scaling and root planning – four or more teeth per quadrant; one to three teeth per quadrant; limited to 1 per quadrant every 24 months, not to exceed four unique quadrants every 24 months.

B. Full mouth debridement to enable comprehensive evaluation and diagnosis, limited to 1 per 36 months.

C. Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, cannot be used the same day as scaling or root planing.

We will provide benefits for services provided by a dentist through telemedicine if the charges would otherwise be considered covered expenses under this policy.

Amount Payable

We will pay the applicable coinsurance percentage in excess for the actual cost of services and supplies that qualify as covered expenses and are received while the covered person's coverage is in force under the policy.

The maximum benefit per covered person, per calendar year is shown in the policy Data Pages.

What Is Not Covered

No benefits will be paid for any service or treatment for which charges incurred are not identified and included as covered expenses under the policy. You will be fully responsible for payment for any services for which charges incurred are not covered expenses under the policy.

The policy does not pay benefits for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

A. Not a covered expense or for which no charge is made.

B. Covered expenses incurred during the waiting period.

C. Provided prior to the effective date or after the termination date of the policy.

D. Fees/surcharges imposed on the covered person by a provider but that are actually the responsibility of the provider to pay.

E. In excess of the frequency limitations or maximum benefits as shown on the policy Data Pages.

F. Covered expenses which exceed the non-network provider reimbursement, as shown on the policy Data Pages.

G. Which no benefit is described in the policy or on the Data Page.

H. A dental service that is not rendered or that is not rendered within the scope of the dentist's license.

I. Veneers, implant crowns, and ¾ crowns.

J. Replacement within 60 consecutive months of the last placement for full and partial dentures.

K. Replacement of complete dentures, fixed and removable partial dentures, 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 the covered persons non-compliance, the covered person is liable for the cost of the replacement.

L. Replacement of full or partial removable dentures, bridges, crowns, or onlay which can be repaired or restored to natural function.

M. Any implant procedures performed which are not listed as covered implant procedures.

N. Replacement of implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), 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 the covered person’s non-compliance, the covered person is liable for the cost of the replacement.

O. Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service.

P. Telephone consultations or for failure to keep a scheduled appointment without giving the dental office 24 hour notice, or the notice required by the dental office in question.

Q. Any service incurred directly or indirectly as a result of the covered person being intoxicated, as defined by applicable state law in the state in which the loss occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a doctor or voluntary taking of any over the counter drug unless taken in accordance with the manufacturer's recommended dosage.

R. Experimental or investigational treatment or for complications there from, including expenses that might otherwise be covered if they were not incurred in conjunction with, as a result of, or while receiving experimental or investigational treatment.

S. Which arise out of, or in the course of, employment for wage or profit, if the covered person is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law.

T. Intentionally self-inflicted bodily harm (whether the covered person is sane or insane), any act of declared or undeclared war, a covered person taking part in a riot, or a covered person's commission or attempt to commit a felony.

U. Provided by a government plan, program, hospital or other facility, unless by law a covered person must pay and it is otherwise a covered expense or which by law must be provided by an educational institution.

V. Provided without cost to a covered person in the absence of insurance covering the charge.

W. Provided by an immediate family member or someone who ordinarily resides with a covered person.

X. Received outside of the United States, except for a dental emergency.

Y. 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, except as expressly provided in the policy.

Z. Teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis as determined by us.

AA. Performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those

procedures that improve physical appearance such as internal/external bleaching, veneers.)

BB. 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.

CC. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

DD. Changing vertical dimension; restoring occlusion; bite analysis, congenital malformation.

EE. Orthognathic surgery.

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

GG. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal.

HH. Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.

II. Mouthguards; precision or semi-precision attachments; duplicate dentures; harmful habit appliances; occlusal guard except if expressly provided in the policy; replacement of lost or stolen appliances; treatment splints; bruxism appliance; sleep disorder appliance.

JJ. Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies including but not limited to take-home fluoride; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures.

KK. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the covered person's dental visit.

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

MM. Replacement of 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 the covered person's non-compliance, the covered person is liable for the cost of the replacement.

NN. Hospital or other facility charges and related anesthesia charges.

OO. Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis.

PP. Altering vertical dimension and/or restoring or maintaining occlusion. Such procedures include, but are not limited to, equilibrium, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

QQ. Non-intravenous conscious sedation, analgesia, anxiolysis, inhalation of nitrous oxide and conscious sedation, unless expressly provided for in the policy.

RR. Charges for dental services that are not documented in the dentist records, that are not directly associated with dental disease, or that are not performed in a dental setting.

SS. Orthodontic services.

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

UU. Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations).

VV. Two or more dental services are submitted and the dental services are considered part of the same dental service to one another, we will pay the most comprehensive dental service.

WW. Two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one dental service contradicts the need for the other dental service), we will pay for the dental service that represents the final treatment.

XX. Surgical extractions of wisdom teeth.

Term of Coverage and Renewability

The policy term begins as of the effective date of the policy. You may keep the policy in force by paying us the required premium as it comes due. However, we

may cancel the policy if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim.

Premium

At any policy anniversary date, we may change the rate table used for the policy form. Each premium will be based on the rate table in effect on that premium's due date. The type and level of benefits and place of residence on the premium due date are some of the factors that could be used in determining your premium rates. At least 60-days written notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under the policy or a change in a covered person's health.

ELECTRONIC DELIVERY TERMS AND CONDITIONS

You will receive your Required Plan Communications electronically instead of receiving paper copies through the U.S. Mail. We will send you an email when a document is ready to view online.

Not all communications require permission before sending electronically. This Notice only applies when permission is required. Communications are based on the Plan(s) you have. You will get new types of communications as they become electronic. If there is not an electronic version, we will send by mail. Occasionally, in addition to electronic delivery, you may also receive a hard copy document.

You can request a free paper copy of documents that we are required to provide you by calling the phone number on your insurance ID card.

Your consent remains in effect until you withdraw it. You may withdraw your consent at any time and choose to begin receiving paper mailings by changing your delivery preferences on the member website or by calling the phone number on your insurance ID card. Changes may take up to seven business days to process.

It is your responsibility to notify us of any changes to your email address and your failure to do so may cause delayed communications. If attempts are made to deliver information to any email address you provide and the message is returned as undeliverable after several attempts and that email address is not updated by you, we will assume that you have withdrawn consent for electronic delivery and will begin sending the information to you in paper format. To ensure that you continue to receive emails from us, add the email "from" address to your email address book or safe list. To update your email address, go to your member website or you can call the phone number on your insurance ID card.

If you change plans or add a benefit, program, product or service, we will use the same contact information, when possible, to electronically deliver Required Plan Communications related to those services.

Requirements to access and retain information – in order to receive and retain electronic communications, you must have access to a computer or other device that is capable of mobile or internet access and complete your registration for the member website. This page contains documents in PDF format. PDF (Portable Document Format) files can be viewed with Adobe® Reader®. If you don't already have this viewer on your computer, download it free from the Adobe website (http://get.adobe.com/reader/).

☐ I hereby consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. All of the Communications between the time you submit your consent and withdraw your consent will remain valid and binding on both you and us notwithstanding your withdrawal.

☐ I hereby DO NOT consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. If you do not consent, we will conduct all future business with you in paper form.

X _____
Primary Applicant *(You)*

X _____
Parent/Guardian *(if you are a minor)* Relationship

_____
Primary Applicant's *(Your)* Email Address

_____
Parent/Guardian's *(if you are a minor)* Email Address

_____
Date

_____
Policy Number