California 2017 • Signature Value • Dental 160

Smile, we've got you covered.

Cost-effective dental benefits for individuals.

UnitedHealthcare Dental®

We give you something to smile about.

Your health benefits just aren't complete without dental coverage.

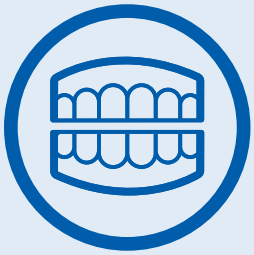
Whether you need coverage for yourself or for a growing family, you'll appreciate UnitedHealthcare Dental 160 plan that provides a wide range of benefits. Routine exams are covered at no charge. And the plan covers a range of preventive, routine and major services at a fraction of what you would pay without coverage. There's even an orthodontic plan with special pricing. Now, that's worth smiling about!

The UnitedHealthcare Dental 160 plan is simple to use. There are no claim forms and no deductibles. Your annual premiums cover common dental procedures to keep your smile healthy. (See the Benefit & Copayment Highlights inside.)

The dentist just for you.

When you join United Healthcare Dental ("UnitedHealthcare Dental 160 or The Plan"), you'll select a contracted dentist from our directory to oversee your dental care. All dentists are rigorously screened before they're added to our network. With our large DHMO California network, you're sure to find a dentist you're comfortable with at a location that's convenient for you.

For a provider directory, please visit our Web site at **myuhc.com** or contact Customer Service at **1-800-22-TEETH (1-800-228-3384)**.



Brace yourself: orthodontia is included too.

Straight teeth are important, not only for a great-looking smile, but for the lifelong health of your teeth, gums and mouth. That's why UnitedHealthcare Dental 160 includes a value-priced orthodontic program. You pay a specially negotiated fee (most orthodontists accept payment plans), plus startup, retention and final records fees.

Your Plan primary care office submits a referral form. Then, the Plan sends you an Explanation of Benefits which includes the name and location of a contracted orthodontist who can provide the orthodontic treatment.

It's easy to enroll.

1. Fill out the attached enrollment form and if choosing the ACH method of payment, be sure to fill out the Pre-Authorization payment application.
2. Indicate which dental office you've chosen. Choose the dental office from our Dentist Directory by visiting myuhc.com or by calling **1-800-22-TEETH (1-800-228-3384)**.
3. Include a check for your enrollment fee and annual premium payable to United Healthcare Dental. Make sure we receive your enrollment form and payment by the 20th of the month to ensure coverage begins the first of the following month.

   Send enrollment form and payment to:

   ATTN: M/S CA124-0151
   UnitedHealthcare Dental
   PO Box 6044
   Cypress CA 90630

Make payments even easier by selecting our monthly auto pay, which allows us to automatically debit your personal checking account each month. This payment option authorization can be found on the enrollment form inside.

2017 Dental 160 rates are noted below by region.

You may select to pay on a monthly basis or save by making an annual payment.

1

Region 1: Alameda, Contra Costa, El Dorado, Fresno, Kern, Los Angeles, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Ventura counties:

Monthly Pay			Annual Payment Option	
Subscriber	$17.10	Or **save** when you select the Annual Payment Option	Subscriber	$198.00
Couple	$27.07		Couple	$313.44
Family	$38.19		Family	$442.20
Total	$23.63			

2

Region 2: Butte, Marin, Solano, Sonoma, Stanislaus counties:

Monthly Pay			Annual Payment Option	
Subscriber	$42.58	Or **save** when you select the Annual Payment Option	Subscriber	$493.08
Couple	$84.79		Couple	$981.96
Family	$132.07		Family	$1,529.40

3

Region 3: Monterey, San Louis Obispo, Santa Barbara, Tulare counties:

Monthly Pay			Annual Payment Option	
Subscriber	$78.84	Or **save** when you select the Annual Payment Option	Subscriber	$912.96
Couple	$156.99		Couple	$1,818.00
Family	$237.32		Family	$2,748.24

For all other areas, please call **1-800-22-TEETH (1-800-228-3384).**

Quality dental care... Broad coverage...
Cost-effective premiums and copayments...

So, are you smiling yet?

Benefit and copayment highlights:

Preventive Services	Member Pays:
Office visit	No Charge
X-rays, full mouth	No Charge
Single film	No Charge
Each additional film	No Charge
Teeth cleaning	No Charge
Topical fluoride (under age 18)	No Charge
Sealants (per tooth; under age 18)	Not Covered
Diagnostic casts (non-orthodontic)	$10.00
Emergency treatment (palliative)	$10.00
Office visit (after-hours)	$20.00
Routine Services	
Restorative Dentistry	
Amalgam restorations (cavities involving permanent teeth)	
One tooth surface	$15.00
Two tooth surfaces	$20.00
Three tooth surfaces	$26.00
Resin restorations, per tooth (anterior)	$25.00
As above, involving incisal edge	$28.00
Resin restorations, per tooth (posterior)	$66.00-$102.00
Pin retention in addition to final restoration, per tooth	$5.00
Sedative base	$7.00
Oral Surgery	
Extraction (uncomplicated)	$16.00
Each additional tooth (same visit)	$10.00
Soft tissue impaction	$50.00
Partially bony impaction	Not Covered
Completely bony impaction	Not Covered
Biopsy of oral tissue (soft)	$10.00
Biopsy of oral tissue (hard)	$16.00
Surgical removal of an erupted tooth	$40.00
Alveoloplasty (not in conjunction with extractions), per quadrant	$80.00
Alveoloplasty in addition to tooth extraction, per quadrant	$90.00
Drain abscess/intraoral	$30.00
Drain abscess/extraoral	$30.00
Frenectomy	$50.00
Endodontics	
Pulp capping (direct)	$10.00
Pulp capping (indirect)	$24.00
Therapeutic pulpotomy	$22.00
Root canals - Anterior	$100.00
Root canals - Bicuspid	$130.00
Root canals - Molar	$175.00
Prefabricated post	$50.00
Cast post and core	$65.00
Periodontics	
Gingival curettage, per quadrant	$40.00
Gingivectomy, per quadrant	$115.00
Muco-gingival surgery, per quadrant	Not Covered
Gingivectomy, per tooth	$20.00
Periodontal maintenance (once every 6 months)	$20.00
Occlusion adjustment	No Charge

Major Services	Member Pays:
Crowns and Pontics	
Stainless steel, primary tooth	$30.00
Resin crown †	$85.00
Full metal crown*	$145.00
3/4 metal crown*	$140.00
Porcelain crown †	$130.00
Porcelain with metal crown* †	$165.00
Cast post and core, in addition to crown*	$ 65.00
Pontic, cast metal (base)	$145.00
Pontic, porcelain with metal*	$165.00
Inlay recementation	$12.00
Crown recementation	$12.00
Bridge recementation	$18.00
Prosthetics	
Denture adjustment	$12.00
Replace tooth, per tooth	$23.00
Denture repair	$28.00
Denture reline (office)	$35.00
Denture reline, lab-processed	$65.00
Interim partial denture	$60.00
Partial denture, upper or lower (including any conventional clasps, rests, and teeth)*	$225.00
Partial denture (cast metal base with resin saddle), upper or lower (including any conventional clasps, rests, and teeth)*	$255.00
Complete denture, upper or lower	$250.00
Add tooth or clasp to existing partial	$31.00
Fixed space maintainer	$55.00
Removable acrylic space maintainer	$55.00
Clasps, each additional, for space maintainer	No Charge

* plus actual lab cost of gold.
† not for molars.
Dentist may charge $20.00 for broken appointments if not notified at least 24 hours in advance.

Orthodontics	
Class I (teeth straightening)	$1,895.00
Class II (correction of overbite)	$1,895.00
Class III (correction of underbite)	$1,895.00

Specific copayment levels have also been set for startup and retention services. The orthodontic benefit covers: consultation, retention, banding, and monthly office visits for 24 months.

Orthodontic treatment must be provided by a UHC Dental Panel Orthodontist. A referral must be submitted by the assigned general dentist, and an orthodontist will be assigned by UHC Dental.

Refer to the Evidence of Coverage and Disclosure Form booklet and the Orthodontic Information Sheet for complete details of benefits, exclusions, limitations, and plan description. There is no specialty referral for the UHC Dental 160 plan. Copayments are applicable at participating general dentist offices only.

The Dental premium includes expenses related to state & federal taxes, fees and assessments. It may also include additional new taxes, fees and assesments from the Affordable Care Act.

UnitedHealthcare Dental®

Individual member enrollment 2017.

Instructions for completing enrollment form.

- Check all appropriate boxes and print all information clearly. (Please retain the brochure information until you receive your ID card.)
- Subscriber: Fill out section completely. Remember to indicate the Provider Number/Dentist/City you have selected.
- Dependents: All dependents you wish to be covered should be listed in this section with their selected Provider (Dentist).
- Method of Payment: Please indicate your preferred method of payment, Monthly Auto Pay, Monthly Pay by Check, Credit Card or Annual Payment. Should you choose the Monthly Auto Pay option, complete and sign the Pre-Authorized Payment Application on the adjacent page. UHC Dental will then automatically deduct the monthly premium from your checking account. Or, if you select the Pay by check option, please include a check made payable to UHC Dental for the annual or monthly premium and one-time enrollment and processing fee of $15.00.
- Terms and Conditions: Read the Terms and Conditions on the adjacent page and sign in the box at the "X" on the bottom of this sheet. This form must be signed for coverage to be effective. Your payment and completed enrollment form must be received by the 20th of the month for coverage to be effective the 1st of the following month.

Subscriber (you)

Please complete all sections. This form cannot be processed if information is incomplete.

Last Name	First Name	Middle Initial

Sex ☐M ☐F	Date of Birth / /	SSN / /	Home ( )

Mailing Address:	City	State	Zip	Work ( )

Provider Number	Dentist Name/City	Have you received treatment from this dental office? ☐Yes ☐No

Email	Cell ( )

Dependents (your spouse and/or children)

Remember to select a provider. **Be sure to read the terms.**

1

Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial

Sex ☐M ☐F	Date of Birth / /	SSN / /

Provider Number	Dentist Name/City	Have you received treatment from this dental office? ☐Yes ☐No

2

Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial

Sex ☐M ☐F	Date of Birth / /	SSN / /

Provider Number	Dentist Name/City	Have you received treatment from this dental office? ☐Yes ☐No

3

Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial

Sex ☐M ☐F	Date of Birth / /	SSN / /

Provider Number	Dentist Name/City	Have you received treatment from this dental office? ☐Yes ☐No

4

Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial

Sex ☐M ☐F	Date of Birth / /	SSN / /

Provider Number	Dentist Name/City	Have you received treatment from this dental office? ☐Yes ☐No

Method of payment

☐ Monthly Auto Pay.
Complete the attached Pre-Authorized Payment Application and include a voided check. A one-time non-refundable enrollment and processing fee of $15.00 will be debited from your checking account along with your first month's premium.

☐ Monthly Pay by Check.
Include a check payable to UnitedHealthcare Dental for your monthly premium, including a one-time non-refundable enrollment and processing fee of $15.00.

☐ Pay by Credit Card (over the Phone).
Please circle one (one-time, recurring, annual). Including a one-time non-refundable enrollment and processing fee of $15.00.

or **save** when you select the **Annual Payment Option**...

☐ Annual Payment.
Include a check payable to United Healthcare Dental for your annual premium, including a one-time non-refundable enrollment and processing fee of $15.00.

UHC Dental Signature Value (HMO) Dental 160 plan is not available in all counties. All dental care must be provided by a network dentist; please check the dentist listing for available dentists. Benefits for the UnitedHealthcare Dental® Signature Value DHMO plans are offered and provided by Dental Benefit Providers of California, Inc.

I understand and agree to the terms and conditions on the adjacent page.

X

Subscriber Signature (This form must be signed by the Subscriber for coverage to be effective.) Date

Be sure to read the terms and conditions below and sign in the box at the "X" located below the Method of Payment section on the prior page.

Mail To:
ATTN: M/S CA124-0151
UnitedHealthcare Dental
PO Box 6044
Cypress CA 90630

Telephone:
1-800-22-TEETH or
1-800-228-3384
Fax: (714) 784-3730

Terms and Conditions

Please complete all sections. This form cannot be processed if information is incomplete.

I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical/dental malpractice (that is as to whether any dental services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and UHC Dental or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. However, in the event the amount in controversy in the dispute including any claims of damage is not greater than $5,000.00, such disputes are not subject to binding arbitration hereunder. Disputes in which more than $5,000.00 is in controversy will not be resolved by a lawsuit or resort to court process, except as applicable law may provide for judicial review of arbitration proceedings. By enrolling in UHC Dental both member (including any heirs or assigns) and UHC Dental entities agree to waive the constitutional right to a jury trial and instead voluntarily agree to the use of binding arbitration as described in the Evidence of Coverage. Request for dis-enrollment or changes in coverage must be received in writing by the 20th of the month to be effective same month. You can fax, mail or email changes:

Fax: 714-784-3730
Email: IndividualDHMODental@uhc.com
Mail: ATTN: M/S CA124-0151
UnitedHealthcare Dental
PO Box 6044
Cypress CA 90630

Pre-authorized Payment Application

Complete this section only if you want your monthly premium automatically deducted from your checking account and provide a voided check.

Our Pre-Authorized Payment Plan

It's the forget-proof method of paying your premium — almost as easy as payroll deduction. Just authorize us to debit your personal checking account each month. We'll do the rest. There will be no more paperwork for you and no more checks to write. No worries about monthly late-payment charges. And you'll save on postage and envelopes. It's easy, reliable, and automatic.

Authorized Agreement for Pre-Arranged Payments (Debits)

I (we) hereby authorize UHC DENTAL to initiate debit entries to my (our) checking account indicated for the subscriber listed below, and the bank named below, herein called BANK, to debit the same to such account.

2017 Calendar for Auto Debit

Jan 25th	Apr 24th	Jul 25th	Oct 25th
Feb 22rd	May 25th	Aug 25th	Nov 24th
Mar 26th	Jun 25th	Sep 24th	Dec 25th

The auto debit process is 7 calendar days prior to the last day of the month except when that day is Saturday; then it will be Sunday. Please have your funds available for withdrawal on this day.

Subscriber Name (print clearly) _____

Account No. (please enclose one voided check) _____

Bank Name _____ Bank Phone _____

Street Address _____

City _____ State _____ ZIP _____

This authority is to remain in full force and effect until BANK has received written notification from me (or either of us) of its termination in such time and in such manner as to afford BANK a reasonable opportunity to act on it. A customer has the right to have the amount of an erroneous debit immediately credited to his account by BANK up to 15 days following issuance of statement of account or 45 days after the charge, whichever comes first.

Name on Bank Account (print clearly) _____

Signature of Bank Account Holder _____ Date _____

☐ Agency ☐ Broker ☐ UHOne Sales

Name	ID Number	Phone ( )	
Address	City	State	ZIP
Email Address			

Individual dental benefits that will make you smile!

ATTN: M/S CA124-0151
UnitedHealthcare Dental
PO Box 6044
Cypress CA 90630

Customer Service
1-800-22-TEETH (1-800-228-3384)

Visit our Web site @ **myuhc.com**
(Network: CA DHMO-Legacy PacifiCare)

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