UHC DHMO Dental PLAN* 161

ENROLLMENT INSTRUCTIONS

Please Type or Print Clearly using only Black Ink, DO NOT USE Felt Tip Pens.

MEMBER / APPLICANT INFORMATION:

Member/Applicant: _____

Local REALTOR ® Assoc. Name: _____

E-Mail Address: _____

Requested effective date of coverage: 1st of _____, 20__

New Enrollee [ ] **Current Benefits Store Member Changing Plans [ ]**

Remember to attach your business card and this form to your application
The applicant must be a member of a Local REALTOR® Association or a W2 Employee of a member firm.

SELECTING YOUR PLAN:

[ ] Spectera - Unitedhealthcare Vision

COMPLETING THE APPLICATION:

USE BLACK INK AND COMPLETE ALL SECTIONS

EFFECTIVE DATE OF COVERAGE:

Applications are accepted (must be received in our office) be the 15th of the current month for coverage to be effective the 1st of the following month.

To avoid confusion about the effective date of coverage, make sure to clearly show the requested effective date of coverage you are applying for on the application, your premium check and this form.

Applications are batched by group to the insurers monthly. Any application received after the 15th of the current month will be part of the next month's application batch.

TO ENROLL:

Review the application for accuracy, sign, date, and return to us with your premium. **Make Checks Payable to The Benefits Store Trust Account.**

U.S. MAIL(1St Class or Priority)
ATTN: ENROLLMENT
Benefits Store, Inc.
PO Box 238, Alamo, CA 94507

PROCESSING REQUIREMENT:

NOTE: Incomplete applications or applications without the correct premium included cannot be processed.

One (1) months premium is required with your application.

www.BenefitsStore.com
CA Insurance License No.: 0680704
Voice: (800) 446-2663 - Fax: (925) 855-2051

UHC DHMO Dental PLAN* 161

ENROLLMENT INSTRUCTIONS

PREMIUM PAYMENTS:

You have four (4) ways to pay your monthly premium:

Electronic Funds Transfer (EFT)
Monthly Invoice/Check
On-Line Bill Payment
Credit Card Payment/Visa, MasterCard, Discover or American Express

For your convenience we have included an EFT Authorization form with the Enrollment Form.

APPLICATION PROCESSING:

Allow 7 business days after the 15th of the current month for the processing of your application and for you to appear in the Vision Plan's database. An Email Confirmation will be automatically generated to you with your group policy number and plan information. DON'T DELAY – ENROLL TODAY! To avoid this delay we urge you to submit your application to us as soon as possible.

You should not cancel your current coverage until you are notified of your new coverage.

For verification of your new coverage, E-mail:

Enrollment@BenefitsStore.com

*This program is a special benefit for members of local REALTOR® Associations within California. Refer to the Enrollment Materials and Benefit Booklet for a complete description of the plans. Be advised that your Association, Benefits Store, Inc. and their agents do not control premiums or coverage provided by these plans. Association members participating in these plans do so voluntarily.

www.BenefitsStore.com
CA Insurance License No.: 0680704
Voice: (800) 446-2663 - Fax: (925) 855-2051

(DO NOT STAPLE)

CALIFORNIA

Small Business Employee Enrollment Form

UnitedHealthcare®

UnitedHealthcare Insurance Company
UnitedHealthcare of California

To speed the enrollment process, please be thorough and fill out all sections that apply.

To Be Completed by Employer

Group Name/Number

Requested Effective Date of Insurance / Health Plan Coverage / Date of Change / /

Date of Hire / /

Position/Title

Hours Worked Per Week

Reason for Application
- ☐New Group Plan
- ☐New Hire
- ☐Dependent Add/Delete
- ☐Annual Open Enrollment
- ☐Change Name/Address
- ☐Late Enrollee
- ☐Termination Date: ____/____/____
- ☐Waiving Coverage (Complete Sections A and E)
- ☐Life Event/Date ____
- ☐Status Change ____
- ☐Other ____

Employee Type (check all that apply)
- ☐Active ☐Union ☐Non-Union ☐Retired
- ☐Hourly ☐Salary ☐Other ____
- ☐COBRA ☐Cal-COBRA
- Start Date ___/___/____ End Date___/___/____
- Indicate Qualifying Event ____
- Original Qualifying Event Date
- Start Date ___/___/____ End Date___/___/____

A. Employee Information

Complete All Sections
If you are waiving coverage, please complete only Sections A and E

Last Name	First Name	MI	Social Security Number	Home Phone/Cell / Work Phone

Address	Apt #	City	State	ZIP Code	Email Address

Date of Birth / /

Sex ☐M ☐F

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partner

Preferred Language: ☐English ☐Spanish ☐Chinese ☐Vietnamese ☐Korean ☐Other ____

Primary Care Physician[1] Name: ____
Address ____
ID# ____ Existing Patient Medical ☐Yes ☐No

Primary Care Dentist[2] Name: ____
ID#: ____
Existing Patient Dental ☐Yes ☐No

B. Dependent Information

List All Enrolling (attach sheet if necessary)

Name (Last, First, M)
Social Security Number ___-___-____
Sex ☐M ☐F
Relationship[3] Spouse/Domestic Partner
Birth Date ___/___/____

Address (if different from Employee)

Preferred Language
☐English ☐Spanish ☐Chinese ☐Vietnamese
☐Korean ☐Other ____

Primary Care Physician[1] Name: ____
Address: ____
ID# ____ Existing Patient Medical ☐Yes ☐No

Primary Care Dentist[2] Name: ____
ID#: ____
Existing Patient Dental ☐Yes ☐No

Name (Last, First, M)
Social Security Number ___-___-____
Sex ☐M ☐F
Relationship[3] Dependent
Birth Date ___/___/____

Address (if different from Employee)

Please check box when selecting HMO health plan coverage:
Permanently disabled and age 26 or older[4] ☐Yes ☐No

Preferred Language
☐English ☐Spanish ☐Chinese ☐Vietnamese
☐Korean ☐Other ____

Primary Care Physician[1] Name: ____
Address: ____
ID# ____ Existing Patient Medical ☐Yes ☐No

Primary Care Dentist[2] Name: ____
ID#: ____
Existing Patient Dental ☐Yes ☐No

IMPORTANT: (1) Please use the UnitedHealthcare Provider Directory to select a Primary Care Physician for yourself and each of your covered dependents for products requiring a Primary Care Physician designation. (2) Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered dependents for products requiring a Primary Care Dentist designation. (3) For court-ordered dependent, legal documentation must be attached. (4) Applicable to HMO health plan coverage selection: If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

Subscriber Last, First Name _____ **SSN** _____

B. Dependent Information (continued)

Name (Last, First, M)	Sex	Relationship[3]	Birth Date
Social Security Number ___-___-____	☐M ☐F	Dependent	___/___/_____
Address (if different from Employee)			Please check box when selecting HMO health plan coverage: Permanently disabled and age 26 or older[4] ☐Yes ☐No
			Preferred Language ☐English ☐Spanish ☐Chinese ☐Vietnamese ☐Korean ☐Other _____
Primary Care Physician[1] Name: _____ Address: _____ ID# _____ Existing Patient Medical ☐Yes ☐No			Primary Care Dentist[2] Name: _____ ID#: _____ Existing Patient Dental ☐Yes ☐No

Name (Last, First, M)	Sex	Relationship[3]	Birth Date
Social Security Number ___-___-____	☐M ☐F	Dependent	___/___/_____
Address (if different from Employee) 123456 123456			Please check box when selecting HMO health plan coverage: Permanently disabled and age 26 or older[4] ☐Yes ☐No
			Preferred Language ☐English ☐Spanish ☐Chinese ☐Vietnamese ☐Korean ☐Other _____
Primary Care Physician[1] Name: _____ Address: _____ ID# _____ Existing Patient Medical ☐Yes ☐No			Primary Care Dentist[2] Name: _____ ID#: _____ Existing Patient Dental ☐Yes ☐No

C. Product Selection

Check the box for each plan you or your dependents are enrolling in. Benefit offerings are dependent on employer selections.

Person	Medical	Dental	Vision	**Medical Plan and Dental Plan Selection –** Write in the Plan Code or Description of the Medical and Dental plan in which you wish to enroll.
Employee	☐	☐	☐	Medical Plan Code/Description: _____
Spouse/Domestic Partner	☐	☐	☐	Dental Plan Code/Description: _____
Dependents	☐	☐	☐	

D. Other Medical Insurance/Health Plan Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this insurance/health plan coverage begins, will you, your spouse/domestic partner or any of your dependents be covered under any other medical insurance/health plan coverage, including another UnitedHealthcare plan or Medicare?

☐YES (continue completing this section) ☐NO (If NO, then skip the rest of the Other Medical Insurance/Health Plan Coverage section.)

Name of other carrier _____

Other Group Medical Insurance/Health Plan Coverage Information (only list those covered by other plan)	Type (B/S/F)[†]	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder/covered employee for other insurance/health plan coverage
Employee:		/ /	/ /	
Spouse/Domestic Partner Name:		/ /	/ /	
Dependent:		/ /	/ /	
Dependent:		/ /	/ /	
Dependent:		/ /	/ /	

[†]B. Enter 'B' when this dependent is covered under both you and your spouse's insurance/health plan coverage (married).
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Coverage provided by "UnitedHealthcare and Affiliates":
Check appropriate box(s) for coverage(s) selected:
Medical ☐ UnitedHealthcare Insurance Company (Insurance Products: Select, Select Plus, Non-Differential PPO)
Medical ☐ UnitedHealthcare of California (HMO)
Dental ☐ UnitedHealthcare Insurance Company or ☐ Dental Benefit Providers of California, Inc.
Vision ☐ UnitedHealthcare Insurance Company
Administrative services provided by United Healthcare Services, Inc., OptumRx, Inc. or OptumHealth Care Solutions, Inc. Behavioral health products by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

Subscriber Last, First Name _____ SSN _____

D. Other Medical Insurance/Health Plan Coverage Information (continued)

If you and/or an enrolling dependent are enrolled in Medicare, complete this section (attach additional sheets if necessary):

Medicare – Employee/Spouse/Domestic Partner/Dependent Name: _____

Medicare ID# _____ (Please attach a copy of your Medicare ID card.)

☐ Enrolled in Part A: Effective Date _____/_____/_____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date _____/_____/_____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date _____/_____/_____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
☐ Disabled ☐ Disabled but actively at work

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work
Are you receiving Social Security Disability Insurance (SSDI)? ☐ YES ☐ NO Start Date_____/_____/_____

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Waiver of Coverage

Complete only if you are waiving coverage for yourself and/or any family member.

I decline coverage for:

	Medical	Dental	Vision
Myself	☐	☐	☐
Spouse/Domestic Partner	☐	☐	☐
Dependent Children	☐	☐	☐
Myself and all dependents	☐	☐	☐

Declining coverage reason:

☐ Spouse's Employer's Plan ☐ Individual Plan ☐ COBRA/Cal-COBRA/AB-1401 from Prior Employer
☐ California Health Benefit Exchange
☐ Covered by Medicare ☐ Medicaid ☐ I (we) have no other coverage at this time
☐ Tri-Care ☐ VA Eligibility ☐ Other _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have been given the right and have been given the chance to apply for coverage. I have decided not to enroll myself and/or my dependent(s), if any.

I now decline to enroll myself, my spouse/domestic partner and/or my dependent(s) in my employer health plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THE GROUP MEDICAL PLAN. THE WAIT OF UP TO TWELVE (12) MONTHS WILL NOT APPLY IF I AND/OR MY DEPENDENTS ARE ENTITLED TO AN OFF-CYCLE ENROLLMENT PERIOD DUE TO CERTAIN CHANGED CIRCUMSTANCES (E.G., ACQUISITION OF A DEPENDENT OR LOSS OF OTHER COVERAGE THROUGH A DEPENDENT.)**

The wait of up to twelve (12) months will not apply if:

1. I certify at the time of initial enrollment that the coverage under another employer health benefit plan, Healthy Families Program, or no share-of-cost Medi-Cal coverage was the reason for declining enrollment, and I lose coverage under that employer health benefit plan, Healthy Families Program, Access for Infants and Mothers (AIM) Program, Covered California, California's Health Benefit Exchange; or no share-of-cost Medi-Cal;
2. My employer offers multiple health benefit plans and I elected a different plan during an open enrollment period;
3. A court orders that I provide coverage under this plan for a spouse or child;
4. I have a new dependent as a result of marriage, domestic partnership, birth, adoption or placement for adoption and if enrollment is requested within 30 days after the marriage, domestic partnership, birth, adoption or placement for adoption;
5. I or my eligible dependents lose health care coverage due to a qualifying event such as loss of employment for any reason other than gross misconduct, reduction of employment hours, death or entitlement to Medicare.

If I am declining enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of other health insurance or group health plan coverage, I must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

Please examine your options carefully before declining this coverage.

Employee Signature (only if waiving coverage for self and/or dependents)	Date _____/_____/_____

Subscriber Last, First Name _____ SSN _____

F. Application Signature

I understand that I am completing a health application and, to the best of my knowledge, that each response is complete and accurate. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) understand that UnitedHealthcare is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. Please maintain a copy of this authorization for your records.

Please note that if UnitedHealthcare can demonstrate you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, UnitedHealthcare may rescind your coverage. UnitedHealthcare will issue a written notice via regular certified mail at least 30 days prior to the effective date of the rescission explaining the basis for the decision of rescission and your appeal rights. No agreement /policy will be rescinded after 24 months following the issuance of the agreement/policy. In addition, in the event it is found you committed an act or practice that constituted fraud, or an intentional misrepresentation of a material fact, UnitedHealthcare may cancel your coverage, as permitted by law.

Employee Signature (if applying for coverage)	Employee Name (please print)	Date _____/_____/_____

G. Binding Arbitration Applicable to UnitedHealthcare of California (HMO) Enrollees Only

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL 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 UNITEDHEATHCARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION IN ACCORDANCE WITH CALIFORNIA ARBITRATION LAW (TITLE 9 OF THE CALIFORNIA CODE OF CIVIL PROCEDURE § 1280 ET SEQ.) EXCEPT WHERE SUCH LAWS MAY BE PREEMPTED BY FEDERAL LAW INCLUDING, BUT NOT LIMITED TO, THE FEDERAL ARBITRATION ACT, 9 U.S.C. SEC. 1, ET SEQ.

Employee Signature (required)	Employee Name (please print) (required)	Date (required) _____/_____/_____

H. Census Information

NOTE: Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: ☐ White ☐ Black, African-American ☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino
☐ American Indian/Alaska Native ☐ Asian ☐ Other Race, please specify _____

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.

The Benefits Store, Inc.

Association Benefits CA License No. 0680704

Credit Card Authorization / Automated Clearing House (ACH) Electronic Funds Transfer (EFT) Authorization

Insured Information	Payment Selection
Name:	CCA [ ] EFT / ACH [ ]
Email:	

Credit Card Transaction

Credit Card Information: Visa [ ] Mastercard [ ] Discover [ ] American Express [ ]

Card Number: ____-____-____-____ ____-____-____-____ ____-____-____-____ ____-____-____-____ **Exp: (MM / YY):** ____-____ / ____-____

Name (as appears on the card): **Authorization Code:** ____-____-____

Address: **City:** **State:** **Zip:**

Monthly Recurring Charges: I authorize the Benefits Store to charge this credit card for the monthly premium on the 20th of each month.
Yes [ ] No [ ] Initials: _____

Credit Card payments will be assessed the full premium rate which includes a 2.5% administration charge.

Automated Clearing House (ACH) / Electronic Funds Transfer (EFT) Transaction

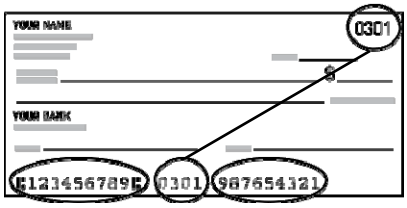
Name on Account: **Name of Financial Institution:**

Routing Number (9 digits): ___-___-___-___-___-___-___-___-___ **Account Number:** ___-___-___-___-___-___-___-___-___-___-___-___-___-___-___

Account Holder Type: Personal [ ] Business [ ] **Account Type:** Checking [ ] Savings [ ]

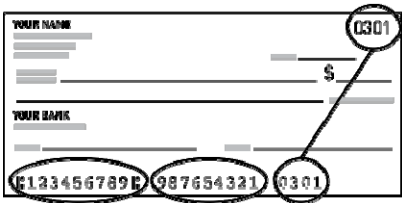
Determining your routing number:
To determine your routing number, refer to your check. The routing number is ALWAYS 9 digits long and it is enclosed by colons. The location of the routing number and account number on you company check varies depending on your bank; for example:

Bank 1



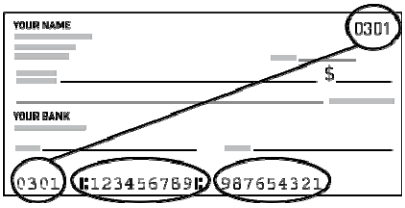
Routing # Check # Account #

Bank 2



Routing # Account # Check #

Bank 3



Check # Routing # Account #

I authorize the Benefits Store to deduct the monthly premium from this bank account.

Yes [ ] No [ ] Initials: _____ 5th of the Month [ ] 15th of the Month [ ]

Monthly Recurring Charges (EFT)

Payment Authorization

Authorization is given to The Benefits Store, Inc. to charge my credit card or debit the banking account listed above. I will not hold The Benefits Store, Inc. responsible for delay, loss or misapplication of funds due to incorrect or incomplete information supplied by me or my depository/credit institution.

Monthly Transactions Authorization

Authorization is given to The Benefits Store, Inc. to charge my credit card or initiate debits (payments) to the financial institution indicated above. This financial institution is authorized to debit the account. This authority is to remain in full force and effect until either a 30 day revocation notice is written to The Benefits Store, Inc. or upon the termination of the coverage through The Benefits Store, Inc. Should a rate change due to policy renewal, age band change or coverage tier occur, I authorize The Benefits Store, Inc. to automatically make the adjustment to my monthly deduction.

Note: I understand and authorize a $25 service charge may be applied against my account for all denied transactions for any reason.

Authorized Signature:	Date:
Payment Amount:	$ _____

The Benefits Store, Inc. - PO Box 238 Alamo, CA 94507 - Membership / Accounting : 800-446-2663 - Email: CustomerService@BenefitsStore.com

BENEFITS STORE, Inc.
Association Benefits

BENEFITS STORE, Inc.
Association Benefits

BENEFITS STORE, INC.
CA Insurance License #0680704

IMPORTANT NOTICE

NEW CUSTOMER SERVICE ACCESS FOR MEMBERSHIP ACCOUNTING AND BILLING QUESTIONS

PHONE NUMBER: (888) 226-8373 FAX: (925) 855-2051

EMAIL: BILLING@BENEFITSSTORE.COM

MAILING ADDRESS: BENEFITS STORE/ MEMBERSHIP ACCOUNTING

PO Box 238

Alamo, CA 94507

Electronic Funds Transfer (EFT)/Automated Clearing House (ACH)

You may do a one time transaction or monthly deduction.

RELIABLE!

EFT/ACH is a method of automatically withdrawing or depositing funds to an individual's bank account.

SAFE!

All EFT/ACH transactions are tracked and governed by the Federal Reserve. Only preauthorized transactions are allowed to be processed.

EFT MONTHLY PAYMENTS!

You will never again need to worry about late payments due to mail delays, misplaced payments or forgotten payments! Your payment will always be made on time.

SIMPLE!

Once you have completed and signed the EFT authorization form, all you need to do is record the payment transaction in your checkbook or savings register on the designated payment date.

Monthly Invoice / Check

Premiums are payable in advance of the month of coverage. You will receive your monthly Premium billing on or about the first of each month

Example: Premiums for July coverage are billed on June 1st and payable (received) on or before June 20th.

Late fees are charged for payments received after the 20th.

Your full payment must be received by the 20th to avoid a late charge. We suggest that you mail your payment on or before the 12th of each month

Payments **MUST** be mailed to:

The Benefits Store, Inc.
P.O. Box 743322
Los Angeles, CA 90074-3322

To assure proper credit make sure to include the top portion of the billing statement with your payment. Also enter the full Subscriber's name in the memo field of your check.

On-Line Bill Payment

Premiums are payable in advance of the month of coverage.

To use On-Line Bill Payment, you will need to arrange for your financial institution to generate a check in payment for your coverage.

As an example, the following links will connect you with major banks for establishing this service

www.Bankofamerica.com
B of A - Online Banking Info

www.Wellsfargo.com
Wells Fargo - Online Banking Information

Your full payment must be received by the 20th to avoid a late charge. We suggest that you initiate your on-line payment on or before the 10th of each month.

Payments **MUST** be mailed to:

The Benefits Store, Inc.
P.O. Box 743322
Los Angeles, CA 90074-3322

To assure proper credit make sure to instruct your bank to show the full Subscriber's name in the memo field of your check.

Credit Card Payment Visa or MasterCard

Premiums are payable in advance of the month of coverage.

We accept Visa, MasterCard for monthly premium payments,

Credit Card payments will be assessed the full premium rate which includes a 2.5% administration charge.

The Credit Card Authorization form may be downloaded from the **Forms section** on our web site www.BenefitsStore.com

To do so, click on the "Forms" tab located in the bar crossing our home page or select the following link Credit Card Authorization Form

Your full payment must be received by the 20th to avoid a late charge. We suggest you initiate your credit card payment on or before the 17th of each month.

For processing, Credit Card Authorization forms must be faxed to (925) 855-2051

Contact us at (888) 226-8373 with any questions about completing this form.

CALIFORNIA
DENTAL 161/D0121
SCHEDULE OF BENEFITS

UnitedHealthcare®

Welcome to the UnitedHealthcare SignatureValue (HMO) Dental 161 plan. This publication is a legal document called Schedule of Benefits. It provides the details of your plan, including Exclusions, along with a list of dental procedures and their corresponding Copayments (the amount you pay to your Assigned Dental Provider Group at the time of your visit).

This publication is part of your Combined Evidence of Coverage and Disclosure Form. Together, these documents explain your coverage. For additional information, please contact Customer Service at 1-800-228-3384.

The following Copayments apply ONLY when treatment is performed by your Assigned Dental Provider Group.

Code	Procedure	Copayment
I. DIAGNOSTIC		
—	Office visit	$0
D0120	Periodic oral examination	$0
D0140	Limited oral evaluation - problem focused	$5
D0150	Comprehensive oral examination	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused	$5
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0210	Radiographs - intraoral - complete series (bitewings included) (once in any 2-year period)	$0
D0220	Radiographs - intraoral - periapical first film	$0
D0230	Radiographs - intraoral - periapical each additional film	$0
D0240	Radiographs - intraoral - occlusal film	$0
D0250	Radiographs - extraoral - first film	NTCV
D0260	Radiographs - extraoral - each additional film	NTCV
D0270	Radiographs - bitewing - single film (4 in any 6-month period)	$0
D0272	Radiographs - bitewings - 2 films (2 in any 6-month period)	$0
D0274	Radiographs - bitewings - 4 films (1 in any 6-month period)	$0
D0277	Radiographs - vertical bitewings - 7 to 8 films	NTCV
D0290	Radiographs - posterior-anterior or lateral skull and facial bone survey film	NTCV
D0310	Radiographs - sialography	NTCV
D0320	Radiographs - temporomandibular joint arthrogram, including injection	NTCV
D0321	Radiographs - other temporomandibular joint films, by report	NTCV
D0322	Radiographs - tomographic survey	NTCV
D0330	Radiographs - panoramic film	$0
D0340	Radiographs - cephalometric film	NTCV
D0350	Radiographs - oral/facial images	NTCV
D0415	Test and lab exams - bacteriologic studies for determination of pathologic agents	NTCV
D0425	Test and lab exams - caries susceptibility tests	NTCV
D0460	Test and lab exams - pulp vitality tests	$0
D0470	Test and lab exams - diagnostic casts	$10
D0471	Test and lab exams - diagnostic photographs	$0
D0472	Accession of tissue, gross exam, preparation and transmission of written report	NTCV
D0473	Accession of tissue, gross and microscopic exam, preparation and transmission of written report	NTCV
D0474	Accession of tissue, gross and microscopic exam, including assessment of surgical margins for presence of disease, preparation and transmission of written report	NTCV
D0480	Processing and interpretation of cytologic smears, including the preparation and transmission of written report	NTCV

* = Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade
† = Over age 15; limited to 7 crowns and/or pontics in any 12-month period; any single fixed bridge is limited to 4 units in length
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Code	Procedure	Copayment
D0501	Histopathologic examinations	$0
D0502	Other oral pathology procedures, by report	$0
D0999	Unspecified diagnostic procedure, by report	NTCV
II. PREVENTIVE		
D1110	Prophylaxis - adult (once every 6 months)	$0
D1120	Prophylaxis - child (once every 6 months)	$0
D1201	Topical application of fluoride (including prophylaxis) - child (under age 18) (once per calendar year)	$0
D1203	Topical application of fluoride (excluding prophylaxis) - child (under age 18) (once per calendar year)	$0
D1204	Topical application of fluoride (excluding prophylaxis) - adult (once per calendar year)	$10
D1205	Topical application of fluoride (including prophylaxis) - adult (once per calendar year)	$10
D1310	Nutritional counseling for the control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	NTCV
D1330	Oral hygiene instruction	$0
D1351	Sealant - per tooth (under age 18 only)	NTCV
D1510	Space maintainer - fixed - unilateral	$55
D1515	Space maintainer - fixed - bilateral	$55
D1520	Space maintainer - removable - unilateral	$55
D1525	Space maintainer - removable - bilateral	$55
D1550	Recementation of space maintainer	$0
III. RESTORATIVE		
D2110	Amalgam - 1 surface, primary	$14
D2120	Amalgam - 2 surfaces, primary	$18
D2130	Amalgam - 3 surfaces, primary	$22
D2131	Amalgam - 4 or more surfaces, primary	$28
D2140	Amalgam - 1 surface, permanent	$15
D2150	Amalgam - 2 surfaces, permanent	$20
D2160	Amalgam - 3 surfaces, permanent	$26
D2161	Amalgam - 4 or more surfaces, permanent	$34
D2330	Resin-based composite - 1 surface, anterior	$25
D2331	Resin-based composite - 2 surfaces, anterior	$25
D2332	Resin-based composite - 3 surfaces, anterior	$25
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior)	$28
D2336	Resin-based composite crown - anterior-primary	NTCV
D2337	Resin-based composite crown - anterior-permanent	NTCV
D2380	Resin-based composite - 1 surface, posterior-primary	$49
D2381	Resin-based composite - 2 surfaces, posterior-primary	$61
D2382	Resin-based composite - 3 or more surfaces, posterior-primary	$63
D2385	Resin-based composite - 1 surface, posterior-permanent	$66
D2386	Resin-based composite - 2 surfaces, posterior-permanent	$85
D2387	Resin-based composite - 3 or more surfaces, posterior-permanent	$102
D2388	Resin-based composite - 4 or more surfaces, posterior-permanent	$117
D2390	Resin-based composite crown, anterior	NTCV
D2391	Resin-based composite - 1 surface, posterior	$66
D2392	Resin-based composite - 2 surfaces, posterior	$85
D2393	Resin-based composite - 3 surfaces, posterior	$102
D2394	Resin-based composite - 4 or more surfaces, posterior	$117
D2410	Gold foil - 1 surface	$15
D2420	Gold foil - 2 surfaces	$20
D2430	Gold foil - 3 surfaces	$26
D2510	Inlay - metallic - 1 surface *	$75
D2520	Inlay - metallic - 2 surfaces *	$90

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D2530	Inlay - metallic - 3 or more surfaces *	$105
D2542	Onlay - metallic - 2 surfaces *	$120
D2543	Onlay - metallic - 3 surfaces *	$130
D2544	Onlay - metallic - 4 or more surfaces *	$140
D2610	Inlay - porcelain/ceramic - 1 surface	NTCV
D2620	Inlay - porcelain/ceramic - 2 surfaces	NTCV
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	NTCV
D2642	Onlay - porcelain/ceramic - 2 surfaces	NTCV
D2643	Onlay - porcelain/ceramic - 3 surfaces	NTCV
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	NTCV
D2650	Inlay - resin-based composite - 1 surface	NTCV
D2651	Inlay - resin-based composite - 2 surfaces	NTCV
D2652	Inlay - resin-based composite - 3 or more surfaces	NTCV
D2662	Onlay - resin-based composite - 2 surfaces	NTCV
D2663	Onlay - resin-based composite - 3 surfaces	NTCV
D2664	Onlay - resin-based composite - 4 or more surfaces	NTCV
D2710	Crown - resin (laboratory) †	$85
D2712	Crown - 3/4 resin-based composite (indirect) †	$85
D2720	Crown - resin with high noble metal * †	$110
D2721	Crown - resin with predominantly base metal †	$110
D2722	Crown - resin with noble metal * †	$110
D2740	Crown - porcelain/ceramic substrate - non-molar †	$130
D2750	Crown - porcelain fused to high noble metal - non-molar * †	$165
D2750	Crown - porcelain fused to high noble metal - molar * †	$245
D2751	Crown - porcelain fused to predominantly base metal - non-molar †	$165
D2751	Crown - porcelain fused to predominantly base metal - molar †	$245
D2752	Crown - porcelain fused to noble metal - non-molar * †	$165
D2752	Crown - porcelain fused to noble metal - molar * †	$245
D2780	Crown - 3/4 cast high noble metal * †	$140
D2781	Crown - 3/4 cast predominantly base metal †	$140
D2782	Crown - 3/4 cast noble metal * †	$140
D2783	Crown - 3/4 porcelain/ceramic (facial veneers not included) †	$98
D2790	Crown - full cast high noble metal * †	$145
D2791	Crown - full cast predominantly base metal †	$145
D2792	Crown - full cast noble metal * †	$145
D2794	Crown - titanium* †	$145
D2799	Provisional crown †	NTCV
D2910	Recement inlay	$12
D2915	Recement cast or prefabricated post and core	$12
D2920	Recement crown	$12
D2930	Prefabricated stainless steel crown - primary tooth	$30
D2931	Prefabricated stainless steel crown - permanent tooth	$45
D2932	Prefabricated resin crown	$45
D2933	Prefabricated stainless steel crown with resin window	NTCV
D2940	Sedative filling	$7
D2950	Core buildup (including any pins)	$0
D2951	Pin retention - per tooth, in addition to restoration	$5
D2952	Cast post and core in addition to crown*	$65
D2953	Each additional cast post - same tooth	$52
D2954	Prefabricated post and core in addition to crown	$50
D2955	Post removal (not in conjunction with endodontic therapy)	NTCV
D2957	Each additional prefabricated post - same tooth (to be used with D2954)	$40

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Code	Procedure	Copayment
D2960	Labial veneer (laminate) - chairside	NTCV
D2961	Labial veneer (resin laminate) - laboratory	NTCV
D2962	Labial veneer (porcelain laminate) - laboratory	NTCV
D2970	Temporary crown, fractured tooth (as a palliative service not in conjunction with a new permanent crown being done)	$0
D2971	Additional procedures to construct new crown under existing partial denture framework	$100
D2975	Coping	$73
D2980	Crown repair, by report	NTCV
D2999	Unspecified restorative procedure, by report	NTCV
IV. ENDODONTICS		
D3110	Pulp cap - direct (excluding final restoration)	$10
D3120	Pulp cap - indirect (excluding final restoration)	$24
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$22
D3221	Pulpal debridement, primary and permanent teeth	$22
D3222	Partial pulpotomy	$0
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	NTCV
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	NTCV
D3310	Root canal therapy - anterior (excluding final restoration)	$100
D3320	Root canal therapy - bicuspid (excluding final restoration)	$130
D3330	Root canal therapy - molar (excluding final restoration)	$175
D3331	Treatment of root canal obstruction; non-surgical access	NTCV
D3332	Incomplete endodontic therapy; inoperable or fractured tooth	$88
D3333	Internal root repair of perforation defects	NTCV
D3346	Retreatment of previous root canal therapy - anterior	$100
D3347	Retreatment of previous root canal therapy - bicuspid	$130
D3348	Retreatment of previous root canal therapy - molar	$175
D3351	Apexification/recalcification, initial visit	NTCV
D3352	Apexification/recalcification, interim medication replacement	NTCV
D3353	Apexification/recalcification, final visit	NTCV
D3410	Apicoectomy/periradicular surgery - anterior	$100
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$100
D3425	Apicoectomy/periradicular surgery - molar (first root)	$100
D3426	Apicoectomy/periradicular surgery (each additional root)	$100
D3430	Retrograde filling - per root	$0
D3450	Root amputation - per root	NTCV
D3460	Endodontic endosseous implant	NTCV
D3470	Intentional reimplantation (including necessary splinting)	NTCV
D3910	Surgical procedure for isolation of tooth with rubber dam	NTCV
D3920	Hemisection (including any root removal) - not including root canal therapy	NTCV
D3950	Canal preparation and fitting of performed dowel or post	$0
D3960	Bleaching of discolored tooth	NTCV
D3999	Unspecified endodontic procedure, by report	NTCV
V. PERIODONTICS		
D4210	Gingivectomy or gingivoplasty - per quadrant	$115
D4211	Gingivectomy or gingivoplasty - per tooth	$20
D4220	Gingival curettage, surgical, per quadrant, by report (no charge if D4341 on same quadrant and same day)	$40
D4240	Gingival flap procedure, including root planing - 4 or more teeth, per quadrant	$200
D4241	Gingival flap procedure, including root planing - 1 to 3 teeth, per quadrant	$100
D4245	Apically positioned flap	NTCV

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Code	Procedure	Copayment
D4249	Clinical crown lengthening - hard tissue	NTCV
D4250	Mucogingival surgery - per quadrant	$200
D4260	Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth or bounded teeth spaces, per quadrant	$200
D4261	Osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or bounded teeth spaces, per quadrant	$100
D4263	Bone replacement graft - first site in quadrant	NTCV
D4264	Bone replacement graft - each additional site in quadrant	NTCV
D4265	Biologic materials to aid in soft and osseous tissue regeneration	NTCV
D4266	Guided tissue regeneration - resorbable barrier, per site	NTCV
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	NTCV
D4268	Surgical revision procedure, per tooth	NTCV
D4270	Pedicle soft tissue graft procedure	NTCV
D4271	Free soft tissue graft procedure (including donor site surgery)	NTCV
D4273	Subepithelial connective tissue graft procedure (including donor site surgery)	NTCV
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	NTCV
D4275	Soft tissue allograft	NTCV
D4276	Combined connective tissue and double pedicle graft	NTCV
D4320	Provisional splinting - intracoronal	NTCV
D4321	Provisional splinting - extracoronal	NTCV
D4341	Periodontal scaling and root planing - 4 or more teeth, per quadrant (max of 4 quadrants per calendar year)	$40
D4342	Periodontal scaling and root planing - 1 to 3 teeth, per quadrant (max of 4 quadrants per calendar year)	$20
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis	$40
D4381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	NTCV
D4910	Periodontal maintenance procedures (following active therapy; once every 6 months)	$20
D4920	Unscheduled dressing change (by someone other than treating dentist)	$0
D4999	Unspecified periodontal procedure, by report	NTCV
VI. DENTURES (PROSTHODONTICS, REMOVABLE)		
D5110	Complete denture - maxillary *	$250
D5120	Complete denture - mandibular *	$250
D5130	Immediate denture - maxillary *	$250
D5140	Immediate denture - mandibular *	$250
D5211	Maxillary partial denture - resin base (including any conventional claspa, rests and teeth) *	$225
D5212	Mandibular partial denture - resin base (including any conventional claspa, rests and teeth) *	$225
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	$255
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	$255
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth) *	$225
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth) *	$225
D5281	Removable unilateral partial denture - 1-piece cast metal (including clasps and teeth) *	$255
D5410	Adjust complete denture - maxillary	$12
D5411	Adjust complete denture - mandibular	$12
D5421	Adjust partial denture - maxillary	$12
D5422	Adjust partial denture - mandibular	$12
D5510	Repair broken complete denture base	$28
D5520	Replace missing or broken teeth - complete denture (each tooth) *	$23
D5610	Repair resin denture base	$28
D5620	Repair cast framework	$28

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Code	Procedure	Copayment
D5630	Repair or replace broken clasp	$31
D5640	Replace broken teeth - per tooth *	$31
D5650	Add tooth to existing partial denture *	$31
D5660	Add clasp to existing partial denture	$31
D5670	Replace all teeth and acrylic on cast metal framework (maxillary) *	$128
D5671	Replace all teeth and acrylic on cast metal framework (mandibular) *	$128
D5710	Rebase complete maxillary denture	NTCV
D5711	Rebase complete mandibular denture	NTCV
D5720	Rebase maxillary partial denture	NTCV
D5721	Rebase mandibular partial denture	NTCV
D5730	Reline complete maxillary denture (chairside)	$35
D5731	Reline complete mandibular denture (chairside)	$35
D5740	Reline maxillary partial denture (chairside)	$35
D5741	Reline mandibular partial denture (chairside)	$35
D5750	Reline complete maxillary denture (laboratory)	$65
D5751	Reline complete mandibular denture (laboratory)	$65
D5760	Reline maxillary partial denture (laboratory)	$65
D5761	Reline mandibular partial denture (laboratory)	$65
D5810	Interim complete denture (maxillary)	NTCV
D5811	Interim complete denture (mandibular)	NTCV
D5820	Interim partial denture (maxillary)	$60
D5821	Interim partial denture (mandibular)	$60
D5850	Tissue conditioning, maxillary	NTCV
D5851	Tissue conditioning, mandibular	NTCV
D5860	Overdenture - complete, by report	NTCV
D5861	Overdenture - partial, by report	NTCV
D5862	Precision attachment, by report	NTCV
D5867	Replacement of replaceable part of semi-precision or precision attachment (male or female component)	NTCV
D5875	Modification of removable prosthesis following implant surgery	NTCV
D5899	Unspecified removable prosthodontic procedure, by report	NTCV
VII. MAXILLOFACIAL PROSTHETICS		
D5900 - D5999	Maxillofacial prosthetics	NTCV
VIII. IMPLANT SERVICES		
D6000 - D6199	Implant services	NTCV
IX. BRIDGES (PROSTHODONTICS, FIXED)†		
D6210	Pontic - cast high noble metal * †	$145
D6211	Pontic - cast predominantly base metal †	$145
D6212	Pontic - cast noble metal * †	$145
D6214	Pontic - titanium * †	$145
D6240	Pontic - porcelain fused to high noble metal * †	$165
D6241	Pontic - porcelain fused to predominantly base metal †	$165
D6242	Pontic - porcelain fused to noble metal * †	$165
D6245	Pontic - porcelain/ceramic †	$165
D6250	Pontic - resin with high noble metal * †	$125
D6251	Pontic - resin with predominantly base metal †	$125
D6252	Pontic - resin with noble metal * †	$125
D6253	Provisional pontic †	NTCV
D6519	Bridge retainer - inlay/onlay - porcelain/ceramic †	NTCV
D6520	Bridge retainer - inlay - metallic - 2 surfaces * †	$90
D6530	Bridge retainer - inlay - metallic - 3 or more surfaces * †	$105
D6543	Bridge retainer - onlay - metallic - 3 surfaces * †	$130

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Code	Procedure	Copayment
D6544	Bridge retainer - onlay - metallic - 4 or more surfaces * †	$140
D6545	Bridge retainer - cast metal for resin bonded fixed prosthesis †	NTCV
D6548	Bridge retainer - porcelain/ceramic for resin bonded fixed prosthesis †	NTCV
D6600	Bridge retainer - inlay - porcelain/ceramic, 2 surfaces †	NTCV
D6601	Bridge retainer - inlay - porcelain/ceramic, 3 or more surfaces †	NTCV
D6602	Bridge retainer - inlay - cast high noble metal, 2 surfaces * †	$90
D6603	Bridge retainer - inlay - cast high noble metal, 3 or more surfaces * †	$105
D6604	Bridge retainer - inlay - cast predominantly base metal, 2 surfaces †	$90
D6605	Bridge retainer - inlay - cast predominantly base metal, 3 or more surfaces †	$105
D6606	Bridge retainer - inlay - cast noble metal, 2 surfaces * †	$90
D6607	Bridge retainer - inlay - cast noble metal, 3 or more surfaces * †	$105
D6608	Bridge retainer - onlay - porcelain/ceramic, 2 surfaces †	NTCV
D6609	Bridge retainer - onlay - porcelain/ceramic, 3 or more surfaces †	NTCV
D6610	Bridge retainer - onlay - cast high noble metal, 2 surfaces * †	$120
D6611	Bridge retainer - onlay - cast high noble metal, 3 or more surfaces * †	$130
D6612	Bridge retainer - onlay - cast predominantly base metal, 2 surfaces †	$120
D6613	Bridge retainer - onlay - cast predominantly base metal, 3 or more surfaces †	$130
D6614	Bridge retainer - onlay - cast noble metal, 2 surfaces * †	$120
D6615	Bridge retainer - onlay - cast noble metal, 3 or more surfaces * †	$130
D6624	Bridge retainer - inlay - titanium * †	$105
D6634	Bridge retainer - onlay - titanium * †	$130
D6720	Bridge retainer - crown - resin with high noble metal * †	$110
D6721	Bridge retainer - crown - resin with predominantly base metal †	$110
D6722	Bridge retainer - crown - resin with noble metal * †	$110
D6740	Bridge retainer - crown - porcelain/ceramic †	$130
D6750	Bridge retainer - crown - porcelain fused to high noble metal * †	$165
D6751	Bridge retainer - crown - porcelain fused to predominantly base metal †	$165
D6752	Bridge retainer - crown - porcelain fused to noble metal * †	$165
D6780	Bridge retainer - crown - 3/4 cast high noble metal * †	$140
D6781	Bridge retainer - crown - 3/4 cast predominantly base metal †	$140
D6782	Bridge retainer - crown - 3/4 cast noble metal * †	$140
D6783	Bridge retainer - crown - 3/4 porcelain/ceramic †	$140
D6790	Bridge retainer - crown - full cast high noble metal * †	$145
D6791	Bridge retainer - crown - full cast predominantly base metal †	$145
D6792	Bridge retainer - crown - full cast noble metal * †	$145
D6793	Bridge retainer - provisional retainer crown †	NTCV
D6794	Bridge retainer - crown - titanium * †	$145
D6920	Connector bar †	NTCV
D6930	Recement bridge †	$18
D6940	Stress breaker †	NTCV
D6950	Precision attachment †	NTCV
D6970	Cast post and core in addition to bridge retainer * †	$65
D6971	Cast post as part of bridge retainer * †	$50
D6972	Prefabricated post and core in addition to bridge retainer †	$50
D6973	Core buildup for bridge retainer (including any pins) †	$0
D6975	Coping - metal * †	$0
D6976	Each additional cast post - same tooth * †	$52
D6977	Each additional prefabricated post - same tooth †	$40
D6980	Bridge repair, by report †	NTCV
D6985	Pediatric partial denture, fixed †	NTCV
D6999	Unspecified, fixed prosthodontic procedure, by report †	NTCV

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X. ORAL AND MAXILLOFACIAL SURGERY		
D7110	Extraction - single tooth - not solely for ortho	$16
D7111	Coronal remnants - deciduous tooth	$10
D7120	Each additional tooth, same visit - not solely for ortho	$10
D7130	Root removal - exposed roots	$40
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$16
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$40
D7220	Removal of impacted tooth - soft tissue	$50
D7230	Removal of impacted tooth - partially bony	$65
D7240	Removal of impacted tooth - completely bony	$90
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$90
D7250	Surgical removal of residual tooth roots (cutting procedure)	$40
D7260	Oroantral fistula closure	NTCV
D7261	Primary closure of a sinus perforation	NTCV
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	NTCV
D7272	Tooth transplantation (includes reimplantation from 1 site to another and splinting and/or stabilization)	NTCV
D7280	Surgical access of an unerupted tooth	NTCV
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption	NTCV
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	NTCV
D7285	Biopsy of oral tissue - hard (bone, tooth)	$16
D7286	Biopsy of oral tissue - soft (all others)	$10
D7287	Cytology sample collection	NTCV
D7290	Surgical repositioning of teeth	NTCV
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	NTCV
D7310	Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	$90
D7311	Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$68
D7320	Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	$80
D7321	Alveoloplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$60
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	NTCV
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	NTCV
D7410	Excision of benign lesion up to 1.25 cm	NTCV
D7411	Excision of benign lesion greater than 1.25 cm	NTCV
D7412	Excision of benign lesion, complicated	NTCV
D7413	Excision of malignant lesion up to 1.25 cm	NTCV
D7414	Excision of malignant lesion greater than 1.25 cm	NTCV
D7415	Excision of malignant lesion, complicated	NTCV
D7420	Radical excision - lesion diameter greater than 1.25 cm	NTCV
D7430	Excision of benign tumor - lesion diameter up to 1.25 cm	NTCV
D7431	Excision of benign tumor - lesion diameter greater than 1.25 cm	NTCV
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	NTCV
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	NTCV
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	NTCV
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	NTCV
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	NTCV
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	NTCV
D7465	Destruction of lesion(s) by physical or chemical method, by report	NTCV
D7470	Removal of exostosis - maxilla or mandible	$115
D7471	Removal of exostosis - per site	$115
D7472	Removal of torus palatinus	$115
D7473	Removal of torus mandibularis	$115
D7480	Partial ostectomy (guttering or saucerization)	NTCV

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D7485	Surgical reduction of osseous tuberosity	$115
D7490	Radical resection of mandible with bone graft	NTCV
D7510	Incision and drainage of abscess - intraoral soft tissue	$30
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$45
D7520	Incision and drainage of abscess - extraoral soft tissue	$30
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$45
D7530	Removal of foreign body, skin, or subcutaneous alveolar tissue	NTCV
D7540	Removal of reaction-producing foreign bodies - musculoskeletal system	NTCV
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	NTCV
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	NTCV
D7610 - D7680	Treatment of fractures - simple	NTCV
D7710 - D7780	Treatment of fractures - compound	NTCV
D7810 - D7899	Reduction of dislocation and management of other temporomandibular joint dysfunctions	NTCV
D7910	Suture of recent small wounds - up to 5 cm	NTCV
D7911	Complicated suture - up to 5 cm	NTCV
D7912	Complicated suture - greater than 5 cm	NTCV
D7920 - D7949	Other repair procedures	NTCV
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones - autogenous or nonautogenous, by report	NTCV
D7955	Repair of maxillofacial soft and hard tissue defects	NTCV
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$50
D7970	Excision of hyperplastic tissue - per arch	NTCV
D7971	Excision of pericoronal gingiva	NTCV
D7972	Surgical reduction of fibrous tuberosity	$115
D7980	Sialolithotomy	NTCV
D7981	Excision of salivary gland, by report	NTCV
D7982	Sialodochoplasty	NTCV
D7983	Closure of salivary fistula	NTCV
D7990	Emergency tracheotomy	NTCV
D7991	Coronoidectomy	NTCV
D7995	Synthetic graft - mandible or facial bones, by report	NTCV
D7996	Implant - mandible for augmentation purposes (excluding alveolar ridge), by report	NTCV
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	NTCV
D7999	Unspecified oral surgery procedure, by report	NTCV

XI. ORTHODONTICS

D8000 - D8999 See special Orthodontia program information attached to this Schedule of Benefits

XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedures	$10
D9210	Local anesthesia not in conjunction with operative or surgical procedures	NTCV
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia	$0
D9220	General anesthesia - first 30 minutes (limited to covered oral surgical procedures involving 1 or more impacted teeth: soft tissue, partially bony or completely bony impactions)	$125
D9221	General anesthesia - each additional 15 minutes	$60
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	NTCV
D9241	Intravenous sedation/analgesia - first 30 minutes	$140
D9242	Intravenous sedation/analgesia - each additional 15 minutes	$70
D9248	Non-intravenous conscious sedation	NTCV
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$25

* = Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade
† = Over age 15; limited to 7 crowns and/or pontics in any 12-month period; any single fixed bridge is limited to 4 units in length
NTCV = The procedure is **Not a Covered Benefit** under this plan
$0 = No Charge for this procedure under this plan

Code	Procedure	Copayment
D9410	House/extended care facility call	NTCV
D9420	Hospital call	NTCV
D9430	Office visit (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$20
D9450	Case presentation, detailed and extensive treatment planning	$0
D9610	Therapeutic drug injection, by report	NTCV
D9630	Other drugs and/or medicaments, by report	NTCV
D9910	Application of desensitizing medicament	NTCV
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	NTCV
D9920	Behavior management, by report	NTCV
D9930	Treatment of complication (post-surgical) - unusual circumstances, by report	$0
D9940	Occlusal guards, by report	NTCV
D9941	Fabrication of athletic mouthguard	NTCV
D9950	Occlusion analysis - mounted case	NTCV
D9951	Occlusal adjustment - limited	$0
D9952	Occlusal adjustment - complete	NTCV
D9970	Enamel Microabrasion	NTCV
D9971	Odontoplasty 1 to 2 teeth; includes removal of enamel projections	NTCV
D9972	External bleaching - per arch	NTCV
D9973	External bleaching - per tooth	NTCV
D9974	Internal bleaching - per tooth	NTCV
D9999	Unspecified adjunctive procedure, by report	NTCV
—	Broken Appointment, with no prior notification at least 24 hours before the scheduled appointment	$20
—	Specialty family calendar year maximum	$1000

* = Member is responsible for Copayment, plus actual lab cost of precious metal and/or other material upgrade
† = Over age 15; limited to 7 crowns and/or pontics in any 12-month period; any single fixed bridge is limited to 4 units in length
NTCV = The procedure is **Not a Covered Benefit** under this plan
$0 = No Charge for this procedure under this plan

EMERGENCY CARE/In Area or Out of Area

Your Assigned Dental Provider Group will be available for Emergency Dental Care 24 hours a day, 7 days a week.

If you need Emergency Dental Care (for example, due to pain, bleeding or swelling, infection or drainage) you must contact your Assigned Dental Provider Group. If you are outside UnitedHealthcare Dental's Service Area and in need of Urgent Dental Services or if your acute emergent dental condition prevents you from contacting your Assigned Dental Provider Group, you may receive care by any licensed dentist. However, you must use the emergency dentist ONLY for relief of pain, or to immediately diagnose and treat a condition that a reasonable person with no special knowledge of dentistry under the circumstance would believe that, if not given immediate attention, may seriously jeopardize the health of the member, seriously impair bodily functions, or result in serious dysfunction of a bodily organ or part. UnitedHealthcare Dental will cover out-of-area follow-up care by a Non-Participating Provider as long as the care continues to meet the definition of Emergency Dental Care.

We will reimburse you for these covered Emergency Dental Services only, subject to applicable Copayments. To receive reimbursement, you do not have to submit a claim form. All you have to do is send us, within 90 days, the itemized bill, marked "PAID," along with a brief explanation of why the Emergency Dental Services were necessary. We will provide reimbursement within 30 days of receipt.

All reimbursement requests should be mailed to:

UnitedHealthcare Dental, M/S LC05-293
P.O. Box 25187
Santa Ana, CA 92799-5187

EXCLUSIONS

(Refer to *Combined Evidence of Coverage and Disclosure Form* booklet for plan Limitations.) The following procedures and services are excluded and not covered Services:

1. Specialty referral benefits, unless otherwise indicated in the Schedule of Benefits, are not covered.
2. Services provided by a prosthodontist are not covered.
3. Cosmetic dental care is not covered.
4. Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities, or Member's home are not covered. When deemed necessary by the Member's Assigned Dental Provider Group, the Member's physician, and authorized by the Plan, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the Schedule of Benefits.
5. Treatment of fractured bones and dislocated joints is not covered.
6. Lost or stolen dentures are not covered.
7. Crowns, or bridgework that are lost, stolen, or damaged due to Member abuse, misuse or neglect are not covered, unless the crown or bridge became dislodged because of recurrent dental caries, tooth fracture, substandard tooth preparation, or poor margins (as previously determined in an examination by the Assigned Dental Provider Group or based upon a review of a pre-existing radiograph).
8. Lost, stolen or broken orthodontic appliances are not covered.
9. Services that are provided to the Member by a state government or agency thereof, or are provided without cost to the Member by a municipality, county or other subdivision are not covered.
10. Charges for services rendered after termination of the Member's eligibility under the Dental Plan are not covered.
11. Work-in-progress: Dental expenses incurred in connection with any portion of the dental services started prior to the effective date of coverage are excluded. The completion of dental or orthodontia services started before the Member's application date or effective date of coverage with UnitedHealthcare Dental, whichever is earlier, or started by a Non-Participating Provider without the prior approval of UnitedHealthcare Dental is not covered. This exclusion does not apply to a current Member:
    - who has temporary restorative services
    - whose tooth was opened and medicated while out-of-area or when the assigned dentist is unavailable to render care.
12. The treatment of congenital and/or developmental malformations, which includes the treatment of congenitally missing and extra, supernumerary teeth and related pathology is not covered.
13. The treatment of non-dentigerous cysts, benign and malignant tumors, neoplasms, and dysplasias is not covered.

14. Dental ridge augmentation, vestibuloplasties, and the excision of benign hyperplastic tissue is not covered.
15. Prescription drugs and over-the-counter medicines are not covered.
16. Any dental procedure unable to be performed in the Member's Assigned Dental Provider Group because of the Member's general health and physical limitations is not covered unless an alternative is recommended by the Assigned Dental Provider Group and the Member's physician and authorized by the Plan.
17. Oral surgery and procedures performed in connection with orthodontic treatment, which include, but are not limited to: orthodontic extraction, serial extraction, orthognathic surgery, transeptal fiberotomy, gingivectomy, and surgery to uncover impacted teeth are not covered.
18. Services rendered by a dental office other than the Member's Assigned Dental Provider Group are not covered. An exception is made for Emergency Dental Care, as defined in the Combined Evidence of Coverage and Disclosure Form.
19. The placement, maintenance, and removal of implants, or crowns and fixed prosthetics supported by implants, are not covered.
20. Restorations to replace or stabilize tooth structure lost solely by abrasion or erosion are not covered. Restorations of natural teeth other than those noted herein are not covered. Such treatment includes, but is not limited to, replacing or stabilizing tooth structure loss by abrasion or erosion.
21. Periodontal splinting/grafting is not covered.
22. Replacement of amalgam restorations with new reiterations of a different material solely to eliminate the presence of amalgam are not covered.
23. Restorations and dental prosthetics that are done solely to alter the vertical dimension of occlusion, alter the plane of occlusion, modify a parafunctional habit, and/or treat temporomandibular joint dysfunction and/or myofacial pain syndrome are not covered Services. If performed, the patient must pay the dentist's Billed Charges. These services include:
    - Realignment of teeth
    - Gnathologic recording
    - Equilibration
    - Occlusal splints and night guards
    - Overlays, implant supported partial dentures and overdentures
    - The replacement of otherwise serviceable existing restorations and dental prosthetics
    - Precision attachments and stressbreakers
24. Dental services that the Plan determines not to be medically necessary or consistent with good professional practice are not covered.
25. Dental services that would not be consistent with the individual Member's dental needs and/or professional recognized standards of dental therapeutics for that Member are not covered.
26. The premature extraction of asymptomatic or non-pathologic impacted teeth at an early stage of tooth development, which, if allowed to further develop and erupt, would reduce the likelihood of needing a more invasive surgery and/or experiencing post-operative complications.
27. Adjunctive dental services that are performed solely to facilitate the performance of another non-Covered Service.
28. Medical services for treatment of fractures, dislocations, tumors, non-dentigerous cysts, and neoplasms, and other medically necessary surgeries of the jaws or related joints are not covered. Requests for such services should be submitted to the Member's full service medical health plan.
29. Relative analgesia (N202 - nitrous oxide) is not covered.

HEALTH PLAN BENEFITS AND COVERAGE MATRIX (GROUP PLANS)

This Matrix Is Intended To Be Used To Help You Compare Coverage Benefits And Is A Summary Only. The Combined Evidence Of Coverage And Disclosure Form And Plan Contract Should Be Consulted For A Detailed Description Of Coverage Benefits And Limitations.

This Uniform Matrix supersedes any other such matrix in the Combined Evidence Of Coverage and Disclosure Form which describes the Plan benefits.

Benefit Description	**Corresponding Copayments or Limitations**
Deductibles:	**There are no deductibles.**
Lifetime Maximums:	**There are no lifetime maximums.**
Calendar Year Maximums:	**There is a Calendar Year Maximum of $1000**

Professional Services:

Comprehensive Oral Exam	**No Charge**
Periodic Oral Exam	**No Charge**
Intraoral X-rays	**No Charge**
Prophylaxis	**No Charge (once every 6 months)**
Topical Application of Fluoride (under 18)	**No Charge**
Amalgam Fillings (primary and permanent teeth)	**$14 to $34 (dependent upon number of tooth surfaces)**
Resin fillings (front teeth only)	**$25 to $28 (dependent upon number of tooth surfaces)**
Crowns (single restorations not associated with a bridge)	**$85 to $245 per unit (dependent upon materials used) plus actual lab cost of precious metal and/or other material upgrade**
Root Canal	**$100 to $175 (dependent upon tooth number)**
Apicoectomy	**$100**
Gingivectomy	**$115 per quadrant**
Gingival Curettage	**$40 per quadrant**
Crown Lengthening	**Not a covered benefit of this plan.**
Periodontal Root Planing and Scaling	**$40 per quadrant**
Full Mouth Debridement	**$40**
Full Mouth Dentures (either immediate or complete)	**$250 for upper, $250 for lower**
Partials (upper/lower)	**$225 to $255 each (dependent upon material)**
Bridges (pontics/abutment crowns)	**$125 to $165 per unit plus actual lab cost of precious metal and/or other material upgrade**
Extractions (not for orthodontic purposes)	**$16 to $90 (dependent upon type of extraction)**

Outpatient Services: Please see Professional Services listed above.

Hospitalization Services: Not a covered benefit of this plan.

Emergency Services: (after-hours office-visit fee when applicable)

In Area: Assigned provider is responsible to provide emergency care 24 hours a day/7 days a week.
$5 to $20 copayment for relief of pain.

Out of Area: If your acute emergent dental condition prevents you from contacting your assigned dentist, you may receive care by any licensed dentist. The Plan will reimburse you for covered emergency services only, subject to applicable copayments.

Ambulance Services: **Not a covered benefit of this plan.**
Prescription Drug Coverage: **Not a covered benefit of this plan.**
Durable Medical Equipment: **Not a covered benefit of this plan.**
Mental Health Services: **Not a covered benefit of this plan.**
Chemical Dependency Services: **Not a covered benefit of this plan.**
Home Health Services: **Not a covered benefit of this plan.**

SAMPLE PEDODONTIC SPECIALTY BENEFITS

- requires referral from your Assigned Dental Provider Group
- subject to specialty family calendar year maximum
- benefits apply through age 18

Copayments listed in this Schedule of Benefits do not apply to Covered Services provided by a pedodontist. Instead, the parent or guardian is responsible for 49% of the pedodontist's contracted rate, as shown in the samples below.

Code	Procedure	Approximate Range of Provider Charges	Patient Copayment
00120	Oral Exam	$10-$54	49% of Provider Charges
00140	Limited Oral	$65	49% of Provider Charges
00150	Comp Oral	$35-$72	49% of Provider Charges
00210	Intraoral X-ray	$39-$67	49% of Provider Charges
00220	Periapical	$18-$33	49% of Provider Charges
00230	Periapical Additional	$5-$60	49% of Provider Charges
00240	Occlusal	$30	49% of Provider Charges
00270	Bitewing-Single	$10	49% of Provider Charges
00272	Bitewing-Two	$12-$60	49% of Provider Charges
00274	Bitewing-Four	$50	49% of Provider Charges
00330	Panoramic	$68	49% of Provider Charges
01120	Child Prophy	$12-65	49% of Provider Charges
01201	Child Prophy w/Fluoride	$34-$82	49% of Provider Charges
01203	Child Fluoride	$6-$25	49% of Provider Charges
01351	Sealant-Per Tooth	$5-$55	49% of Provider Charges
01510	Space Maintainer-Unilateral	$240-$348	49% of Provider Charges
01515	Space Maintainer-Bilateral	$270-$332	49% of Provider Charges
02110	Amalgam-One	$50-$75	49% of Provider Charges
02120	Amalgam-Two	$42-$108	49% of Provider Charges
02130	Amalgam-Three	$93-$125	49% of Provider Charges
02140	Amalgam-One-Perm	$75-$82	49% of Provider Charges
02330	Resin-One	$100-$130	49% of Provider Charges
02331	Resin-Two	$100-$115	49% of Provider Charges
02335	Resin-Four	$215	49% of Provider Charges
02380	Resin-One-Posterior	$42-$62	49% of Provider Charges
02381	Resin-Two-Posterior-Prim	$144	49% of Provider Charges
02385	Resin-One-Posterior-Perm	$119	49% of Provider Charges
02930	Stainless Steel Crown-Prim	$85-$250	49% of Provider Charges
03110	Pulp Cap-Direct	$40	49% of Provider Charges
03220	Pulpotomy	$83-$125	49% of Provider Charges
07110	Extraction-Single	$45-$125	49% of Provider Charges
07120	Extraction-Additional Teeth	$70-$125	49% of Provider Charges
09310	Consultation	$5-$55	49% of Provider Charges
09440	Office Visit-After Hours	$75-$100	49% of Provider Charges
09930	Tx of Complications	$85	49% of Provider Charges

UnitedHealthcare®

YOUR SCHEDULE OF BENEFITS ENDS HERE

ORTHODONTIA program

Questions?
Call our Member Service department at
1-800-22-TEETH (1-800-228-3384)

Visit our Web site at www.myuhcdental.com

ORTHODONTICS (BRACES)[3]

To take advantage of the UnitedHealthcare SignatureValue group dental orthodontic benefit, a member must:

- Be an eligible employee or dependent currently enrolled in a UnitedHealthcare SignatureValue dental plan;
- Not be subject to any exclusion listed for orthodontic coverage;
- Have a written referral to a contracted UnitedHealthcare Dental orthodontist, submitted by the assigned dental Provider Group.

UnitedHealthcare Dental Orthodontic Benefits:

1. Startup services including:
   - Panographic radiographs.
   - All required tracings.
   - All diagnostic study models.
   - All photographs.
   - All case studies.

   Member copayment: $250
   (Services performed by outside laboratories are not a benefit; therefore, the cost is entirely the member's responsibility.)
2. All treatment performed during a 24-month period, including:
   - Consultations and all office visits.
   - Fixed and/or removable appliances (including headgear) required to adequately complete treatment in a satisfactory manner, subject to the limitations and exclusions of the plan.
   - Banding.
   - Retention, if required within a 24-month covered treatment period.

   Member copayment: $1895 for both upper and lower arch
   $947.50 for upper or lower arch only

   If orthodontic treatment requires more than 24 months, members may be charged the orthodontist's regular fees for additional monthly visits as needed, as well as copayments for retention (see item #3 below).
3. Retention is included in the full treatment copayment if started during the 24-month active treatment coverage period. If retention is begun after the 24-month treatment period, then an additional retention copayment is applicable.

   Member copayment: $250 for children up to age 18 (includes upper and lower retainers);
   $300 for adults age 18 and older (includes upper and lower retainers)
4. Final records, if required by your orthodontist, including photographs, models, radiographs or other studies.
   Member copayment: $150
   (Services performed by outside laboratories are not a benefit; therefore, the cost is entirely the member's responsibility.)
5. The following are not covered orthodontic benefits:
   - Lost, stolen, or broken appliances
   - Treatment in progress prior to the effective date of UnitedHealthcare Dental coverage
   - Extractions required for orthodontic purposes
   - Surgical orthodontics or jaw repositioning
   - Myofunctional therapy
   - Cleft palate
   - Micrognathia
   - Macroglossia
   - Hormonal imbalances
   - Orthodontic retreatment when initial treatment was rendered under this plan
   - Palatal expansion appliances
6. If a treatment plan is for less than 24 months, then a prorated portion of the full member copayment shall apply.
7. If member's dental eligibility ends, for whatever reason, and the member is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The member will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
8. If the member has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the member will be charged a $50 consultation fee, plus any lab costs incurred by the orthodontist.
9. A member is eligible for only one 24-month orthodontic treatment period while covered under this Plan.

For orthodontic referrals, the following procedure applies:

The assigned dental Provider Group will complete a written referral form for the member and mail it to UnitedHealthcare Dental. UnitedHealthcare Dental will process the referral request. The referral will be made to a specialist contracted with UnitedHealthcare Dental, who practices in the member's area. A copy of the processed referral is sent to the member, the referring dentist and the selected contracted orthodontist who has agreed to provide these services at reduced fees for UnitedHealthcare Dental members. The member can then call the Orthodontist and schedule an appointment.

[3]One orthodontic benefit under this plan is available per lifetime, per member. A member may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24-month period, the copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24-month benefit period.