A dental plan for individuals and families.

A DHMO plan that gives you simpler benefits for a healthier smile.

UnitedHealthcare®

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 Plan V160 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 Plan V160 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 UnitedHealthcare Dental ("UnitedHealthcare Dental Plan V160 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.

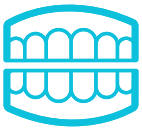
Find your primary care dentist.

Each family member can have their own primary care dentist. Before you enroll, search the network to find the dentist that is right for you.

Online

1. Go to **myuhc.com**.
2. Select Find a Dentist.
3. Select California.
4. Select the "CA DHMO-Legacy PacifiCare" network.

Call Open Enrollment Hotline at **1-888-679-8925.**



Brace yourself: orthodontia is included too.

Straight teeth are important, not only for a great-looking smile, but also for the lifelong health of your teeth, gums and mouth. That's why UnitedHealthcare Dental V160 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 1-888-679-8925.

3. Include a check for your enrollment fee and annual premium payable to UnitedHealthcare 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 CA 124-0152
   UnitedHealthcare Dental
   P.O. Box 6020
   Cypress, CA 90630-0020

Make payments even easier.

Select 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.

2020 Dental V160 rates by region.

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

	1	2	3
Region	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:	Butte, Marin, Solano, Sonoma, Stanislaus counties:	Monterey, San Louis Obispo, Santa Barbara, Tulare counties:
Monthly Pay			
Subscriber	$21.30	$51.91	$46.50
Subscriber + 1	$33.72	$82.14	$73.58
Family	$47.57	$115.90	$103.82

Or save when you select the Annual Payment Option

Annual Payment Option			
Subscriber	$246.71	$601.07	$538.43
Subscriber + 1	$390.44	$951.24	$852.11
Family	$550.88	$1,342.12	$1,202.27

For all other areas, please call **1-888-679-8925.**

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

So, are you smiling yet?

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 also have 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 UnitedHealthcare Dental Panel Orthodontist. A referral must be submitted by the assigned general dentist, and an orthodontist will be assigned by UnitedHealthcare 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 UnitedHealthcare Dental V160 plan. Copayments are applicable at participating general dentist offices only.

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

Individual member enrollment 2020.

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. UnitedHealthcare 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 UnitedHealthcare 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.

Effective Date

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 Code	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

Payor (if not you)

This section must be completed by the individual who will be responsible for paying for the plan.

Last Name	First Name	Middle Initial	Email Address

Address	City	State	ZIP Code

Be sure to read the terms and conditions on the following page, and sign at the "X" by this symbol:

Mail To:
ATTN: M/S CA 124-0152
UnitedHealthcare Dental
P.O. Box 6020
Cypress, CA 90630-0020

Telephone:
1-888-679-8925
Fax: **1-844-608-0601**

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 UnitedHealthcare 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 UnitedHealthcare Dental, both member (including any heirs or assigns) and UnitedHealthcare 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 disenrollment 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: 1-844-608-0601
Email: individualdhmodental@uhc.com

Mail: ATTN: M/S CA 124-0152
UnitedHealthcare Dental
P.O. Box 6020
Cypress, CA 90630-0020

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). Includes 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 UnitedHealthcare Dental for your annual premium, including a one-time non-refundable enrollment and processing fee of $15.00.

UnitedHealthcare Dental Signature Value (HMO) Dental V160 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.

X _____

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

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.

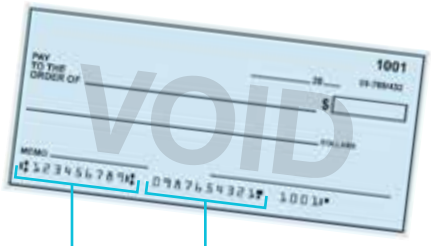
2020 Calendar for Auto Debit

Jan 26	Apr 24	Jul 26	Oct 25
Feb 23	May 25	Aug 25	Nov 24
Mar 25	Jun 24	Sep 24	Dec 25

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.

☐ Automatic Payment(s)

I (we) hereby authorize UnitedHealthcare 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 Number

Account Number

Financial Institution's Name _____

Address _____

City, State, ZIP _____

This 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.

x_____
Authorized Account Signature

Agency / Broker Use Only

☐ Agency ☐ Broker

Name | ID Number | Phone ( )

Address | City | State | ZIP Code

Email Address

Individual dental benefits that will make you smile!

More information?

1-888-679-8925 | **myuhc.com** Network name: CA DHMO-Legacy PacifiCare

ATTN: M/S CA 124-0152, UnitedHealthcare Dental, P.O. Box 6020, Cypress, CA 90630-0020

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

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

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

Online: UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free member phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services:

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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

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

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

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說**中文 (Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)를 사용하시는 경우 언어 지원** 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русский (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

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

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

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

This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact either your employer or the company.

*Benefits for the UnitedHealthcare Dental DHMO plans are offered by Dental Benefit Providers of California, Inc. UnitedHealthcare Dental is affiliated with UnitedHealthcare.

Facebook.com/UnitedHealthcare Twitter.com/UHC Instagram.com/UnitedHealthcare YouTube.com/UnitedHealthcare

UnitedHealthcare®