UnitedHealthcare Insurance Company Enrollment Form

UnitedHealthcare Dental®

2015-2016

Wright State University

IMPORTANT: Coverage will not begin until payment is received and processed.
Send completed application with check made payable to UnitedHealthcare StudentResources to:
UnitedHealthcare StudentResources, PO Box # 809026, Dallas, Texas 75380-9026.

SOCIAL SECURITY NUBER	SCHOOL ID NUMBER	☐ Enroll ☐ Cancel ☐ Change ☐ Address Change ☐ Name Change Date of Change ___/___/___

LAST NAME	FIRST NAME	MI	ENROLLEE'S DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP

TELEPHONE NUMBER Home ( ) Work ( )

☐ Male ☐ Female
☐ Single ☐ Married

PLAN PERIOD
☐ Annual Enrollment Deadline: 08/15/15 Effective and Termination Dates: 07/01/2015-06/30/2016

PLAN COVERAGE ☐ Student ☐ Student + Spouse (or Domestic Partner*) ☐ Student + Child(ren) ☐ Student + Family

INFORMATION FOR DEPENDENT COVERAGE
Spouse & Unmarried Dependent Children Only (Include Date of Birth)

First Name Initial Last Name (if different)	Date of Birth (Mo/Day/Yr)	Relationship**	If child is over age 19, please indicate status and school	
		☐ Wife ☐ Husband ☐ Domestic Partner*	Student at _____ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel ☐ Male ☐ Female ☐ Other Dental Insurance Carrier Name
		☐ Son ☐ Daughter	Student at _____ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel ☐ Male ☐ Female ☐ Other Dental Insurance Carrier Name
		☐ Son ☐ Daughter	Student at _____ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel ☐ Male ☐ Female ☐ Other Dental Insurance Carrier Name
		☐ Son ☐ Daughter	Student at _____ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel ☐ Male ☐ Female ☐ Other Dental Insurance Carrier Name
		☐ Son ☐ Daughter	Student at _____ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel ☐ Male ☐ Female ☐ Other Dental Insurance Carrier Name

* Domestic Partner coverage is determined by your Student Health Plan. Please confirm coverage for Domestic Partners with your medical carrier.
** For court ordered dependent, legal documentation must be attached. Please see school representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible subscriber, please provide address on separate sheet.

Annual	Student	$506.16	Student + Child(ren)	$1,084.20	Student + Spouse	$1,012.56	Student + Domestic Partner	$1,012.56	Student + Family	$1,667.52

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Please send a check or money order for your premium payment, along with your completed and signed enrollment form, to the address indicated. If you would like to use a credit card to enroll, please go to www.uhcsr.com, and use the Find My School's Plan link to search for your school. Select your school name from the search results to go to your school's page, and then select the Enroll Now link to enroll online.

I confirm that the information I have provided on this form is complete and accurate.

I understand that the dental benefit plan I have selected provides reimbursement for certain dental costs which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my dentist or me or dental expenses which I have incurred may not be covered by my dental benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I understand that if I and/or my dependents (including my spouse or domestic Partner), if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at the next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse or domestic partner) because of other dental coverage, I may in the future be able to enroll myself or my dependents (including my spouse or domestic partner) in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, domestic partnership, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, domestic partnership, birth, adoption, or placement for adoption.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The Certificate provides dental benefits only. Review your Certificate carefully.

SIGNATURE:_____DATE:_____

UnitedHealthcare Dental insurance products are either underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut (except in New York), UnitedHealthcare Insurance Company of New York, Hauppauge, New York (New York only), or United Healthcare Services, Inc. UnitedHealthcare Dental Select HMO product is provided or administered by the following UnitedHealth Group companies: Dental Benefit Providers, Inc., Dental Benefit Providers of California, Inc., Dental Benefit Providers of Illinois, Inc., Dental Benefit Providers of Maryland, Inc. and/or Dental Benefit Providers of New Jersey, Inc. * 1st and 2nd Semi Annual Periods provide coverage for the dates indicated and must be enrolled in prior to the indicated deadline date.

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UnitedHealthcare

Voluntary Options PPO/covered dental services

dental plan

Custom P4429

NON-ORTHODONTICS	NETWORK	NON-NETWORK		
Individual Plan Year Deductible	$50	$50		
Family Plan Year Deductible	$150	$150		
Maximum *(the sum of all Network and Non-Network benefits will not exceed plan year maximum)*	$750 per person per Plan Year	$750 per person per Plan Year		
New enrollee's waiting period:				
Plan year deductible applies to preventive and diagnostic services			No (In Network)	No (Out Network)

COVERED SERVICES*	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs	100%	100%	Bite-wing: Limited to 1 series of films per Plan Year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatment (Preventive)	100%	100%	Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	For Covered Persons under the age of 16 years, limited to 1 per consecutive 60 months.
BASIC SERVICES			
Restorations (Amalgam or Anterior Composite)*	80%	60%	Multiple restorations on one surface will be treated as a single filling.
Emergency Treatment / General Services	80%	60%	Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: When clinically necessary.
Simple Extractions	80%	60%	Limited to 1 time per tooth per lifetime.
Oral Surgery (includes surgical extractions)	80%	60%	
Periodontics	80%	60%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
Endodontics	80%	60%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
MAJOR SERVICES			
Inlays/Onlays/Crowns*	50%	40%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	40%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)*	50%	40%	Once per tooth per consecutive 60 months.

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

**The network percentage of benefits is based on the discounted fees negotiated with the provider.

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

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage benefits administrator, the certificate benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

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UnitedHealthcare/Dental Exclusions and Limitations

General Limitations

PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to one time per consecutive 36 months Exception to this limit will be made for Panorex Radiograph if taken for diagnosis of molars, Cysts or neoplasms

BITEWING RADIOGRAPHS Limited to 1 series of films per PlanYear

EXTRAORAL RADIOGRAPHS Limited to 2 films per PlanYear

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months

FLUORIDE TREATMENTS Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months

SEALANTS Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months

SPACE MAINTAINERS Limited to Covered Persons under the age of 16 years. Limited to 1 per consecutive 60 months Benefit includes all adjustment within 6 months of installation

RESTORATIONS Multiple restorations on 1 surface will be treated as a single filling

PIN RETENTION Limited to 2 pins per tooth, not covered in addition to cast restoration

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

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

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

SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam were performed on the same tooth during the visit

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

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

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

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

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

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

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion Limited to 1 time per consecutive 6 months

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than exam and radiographs, were performed on the same tooth during the visit

OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only if prescribe to control habitual grinding

FULL MOUTH DEBRIDMENT Limited to 1 time every consecutive 36 months

GENERAL ANESTHESIA Covered only when clinically necessary

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

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

REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances

General Exclusions

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.
10. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12. Foreign services are not covered unless required as an Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been covered under the policy for 12 continuous months.
15. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO)
19. Placement of dental implants, implants-supported abutments and prostheses. (Not applicable for plans with implants)
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
22. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue
23. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint. (Not Applicable for Plans with TMJ).
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia
25. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
26. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
27. Occlusal guard used as safety items or to affect performance primarily in sports-related activities
28. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
29. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.