



The Service Edge



Dental PPO - 2012 Calendar Year

		P0010 - Dental Low	P4957 - Dental High
Deductible	Individual/Family	\$50/\$150	\$50/\$150
Preventative Coinsurance	In/Out Network	100%/100%	100%/100%
Minor Restorations	In/Out Network	80%/80%	100%/80%
Endo/Perio/Oral Surgery	In/Out Network	80%/80%	100%/80%
Major Services	In/Out Network	NONE	60%/50%
Annual Plan Maximum	In/Out Network	\$1,000/\$1,000	\$1,500/\$1,500
Orthodontia Benefit		NONE	Child Only
Orthodontia Coinsurance	In/Out Network	N/A	50%/50%
Orthodontia Lifetime	In/Out Network	N/A	\$1,500/\$1,000
		<b>MONTHLY RATE</b>	<b>MONTHLY RATE</b>
Single	↳	\$ 26.23	\$ 42.59
EE+ SP	↳	\$ 52.46	\$ 85.18
EE+ Child	↳	\$ 54.88	\$ 89.12
EE + Family	↳	\$ 83.77	\$ 136.03

**UnitedHealthcare Dental®**  
**Consumer MaxMultiplier Options PPO/covered dental services**

dental plan  
P4957

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	\$50		None	
Family Annual Deductible	\$150		None	
Annual Maximum Benefit* (The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)	\$1500 per person per calendar year		\$1500 per person per lifetime	\$1000 per person per lifetime
Annual Deductible Applies to Preventive and Diagnostic Services	No			
Annual Deductible Applies to Orthodontic Services	No			
Waiting Period	No waiting period			
Orthodontic Eligibility Requirement	Children under age 19			

COVERED SERVICES**	NETWORK PLAN PAYS***	NON-NETWORK PLAN PAYS****	BENEFIT GUIDELINES
<b>DIAGNOSTIC SERVICES</b>			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs	100%	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	100%	
<b>PREVENTIVE SERVICES</b>			
Dental Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	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, limit 1 per consecutive 60 months.
<b>BASIC DENTAL SERVICES</b>			
Restorations (Amalgam or Composite)	100%	80%	Multiple restorations on one surface will be treated as a single filling.
General Services (including Emergency Treatment)	100%	80%	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	100%	80%	Limited to 1 time per tooth per lifetime.
Oral Surgery (includes surgical extractions)	100%	80%	
Periodontics	100%	80%	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	100%	80%	
<b>MAJOR DENTAL SERVICES</b>			
Inlays/Onlays/Crowns	60%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	60%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. Occlusal Guard: Covered only if prescribed to control habitual grinding, and limited to 1 guard every consecutive 36 months.
Fixed Partial Dentures (Bridges)	60%	50%	Limited to 1 time per tooth per consecutive 60 months.
<b>ORTHODONTIC SERVICES</b>			
Diagnose or correct misalignment of the teeth or bite	50%	50%	Course of treatment is typically 24 months, with initial payment at banding of 20% and remaining payment spread over the course of treatment

\* This plan includes a maximum benefit award program. Some of the unused portion of your annual maximum benefit may be available in future benefit periods.  
\*\* 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 have 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 fee negotiated with the provider.  
\*\*\*\* The non-network percentage of benefits is based on the schedule of usual and customary fees in the geographic area in which the expenses are incurred.

The Prenatal Dental Care 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: UnitedHealthcare Insurance Company, Hartford, Connecticut; UnitedHealthcare 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.

# UnitedHealthcare/dental exclusions and limitations

Dental Services described in this section are covered when such services are:

- A. Necessary;
- B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
- C. The least costly, clinically accepted treatment; and
- D. Not excluded as described in the Section entitled, General Exclusions.

## GENERAL LIMITATIONS

**PERIODIC ORAL EVALUATION** Limited to 2 times per consecutive 12 months.

**COMPLETE SERIES OR PANOREX RADIOGRAPHS** Limited to 1 time per consecutive 36 months. Exception to this limit will be made for Panorex Radiographs if taken for diagnosis of third molars, cysts, or neoplasms.

**BITEWING RADIOGRAPHS** Limited to 1 series of films per calendar year.

**EXTRAORAL RADIOGRAPHS** Limited to 2 films per calendar year.

**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.

**SPACE MAINTAINERS** Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation

**SEALANTS** Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

**RESTORATIONS** Multiple restorations on one 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.

**PERIODONTAL MAINTENANCE** Limited to 2 times per consecutive 12 months following active and 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 per consecutive 6 months.

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

**OCCUSAL GUARDS** Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.

**FULL MOUTH DEBRIDEMENT** Limited to 1 time every consecutive 36 months.

**GENERAL ANESTHESIA** Covered only where 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, implant-supported abutments and prostheses
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 jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
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 guards 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.

# UnitedHealthcare Dental® Options PPO/covered dental services

dental plan  
P0010/70010

	IN-NETWORK	OUT-OF-NETWORK
<b>Individual Annual Deductible</b>	\$50	\$50
<b>Family Annual Deductible</b>	\$150	\$150
<b>Maximum</b> (combined for both In-Network and Out-of-Network services)	\$1000 per person per calendar year	\$1000 per person per calendar year

<b>Annual deductible applies to preventive and diagnostic services</b>	Yes
<b>For new enrollees, a 12-month waiting period applies to major services</b>	No

COVERED SERVICES	IN-NETWORK PLAN PAYS*	OUT-OF-NETWORK PLAN PAYS**	BENEFIT GUIDELINES
<b>PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES</b>			
Periodic Oral Examinations	100%	100%	Up to 2 per year.
Bite-Wing X-rays	100%	100%	One series of films per year.
Complete Series or Panorex X-rays	100%	100%	One time per 36 months.
Dental Prophylaxis (Cleanings)	100%	100%	Up to 2 per year.
Fluoride Treatments	100%	100%	For covered persons under the age of 16 years, up to 2 per year.
Sealants	100%	100%	For covered persons under the age of 16 years, once per first or second permanent molar every 5 years.
<b>BASIC DENTAL SERVICES (Minor Restorative, Endodontics, Periodontics and Oral Surgery)</b>			
Amalgam Restorations (Fillings)	80%	80%	One restoration allowed per surface every 3 years.
Composite Resin Restorations (Fillings)	80%	80%	One restoration allowed per surface every 3 years.
Space Maintainers	80%	80%	For covered persons under the age of 16 years, once per lifetime.
Root Canal Treatment	80%	80%	Once per site per lifetime.
Root Planing	80%	80%	Once every 24 months per quadrant.
Periodontal Surgery	80%	80%	Once every 36 months per site.
Simple Extraction	80%	80%	
Surgical Extraction including Impacted Wisdom Teeth	80%	80%	
General Anesthesia	80%	80%	When clinically necessary.
Palliative Treatment (Relief of Pain)	80%	80%	Covered as a separate benefit only if no other services except exam and X-rays were performed during the visit.

\*The in-network percentage of benefits is based on the discounted fee negotiated with the provider.

\*\*The out-of-network percentage of benefits is based on the usual and customary rates prevailing in the geographic area in which the expenses are incurred.

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# UnitedHealthcare/dental exclusions and limitations

## GENERAL LIMITATIONS

**ORAL EXAMINATIONS** Covered as a separate benefit only if no other service was done during the visit other than X-rays. Limited to 2 times per calendar year; limited to one time every 6 months.

**COMPLETE SERIES OR PANOREX RADIOGRAPHS** Limited to one time per 36 months.

**BITEWING RADIOGRAPHS** Limited to 1 series of films per calendar year.

**EXTRAORAL RADIOGRAPHS** Limited to 2 films per calendar year.

**DENTAL PROPHYLAXIS** Limited to 2 times per calendar year; limited to once every 6 months.

**DIAGNOSTIC CASTS** Limited to one time per 24 months.

**FLUORIDE TREATMENTS** Limited to Covered Persons under the age of 16 years, and limited to 2 times per calendar year. Treatment should be done in conjunction with dental prophylaxis.

**SEALANTS** Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every 5 years.

**SPACE MAINTAINERS** Limited to Covered Persons under the age of 16 years, once per lifetime. Benefit includes all adjustment within 6 months of installation.

**AMALGAM RESTORATIONS** Multiple restorations on one surface will be treated as a single filling.

**PIN RETENTION** Limited to 2 pins per tooth; not covered in addition to Cast Restoration.

**SEDATIVE FILLINGS** Covered as a separate benefit only if no other service, other than X-rays and exam, were done during the visit.

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

**PERIODONTAL MAINTENANCE** Limited to 2 times within the first 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.

**PALLIATIVE TREATMENT** Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.

**OCCUSAL GUARDS** Limited to one guard every 5 years.

## 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. Any dental procedure not directly associated with dental disease.
5. Any procedure not performed in a dental setting.
6. 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.
7. 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.
8. Expenses for dental procedures begun prior to the Covered Person's eligibility with the Plan.
9. 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.
10. 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.
11. Dental Services provided in a foreign country, unless required as an Emergency.
12. Full mouth radiograph series in excess of once every 36 months. Panoramic radiographs in excess of once every 36 months, except when taken for diagnosis of third molars, cysts, or neoplasms.
13. Acupuncture; acupressure and other forms of alternative treatment.
14. General Anesthesia, except if required for patients under 6 years of age or patients with behavioral problems or physical disabilities.
15. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
16. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
17. 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.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.

# Employee Enrollment Form

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

Group Name/Number

**To Be Completed by Employer**

Requested Effective Date of Coverage/Date of Change / /

Date of Hire / /	Reason for Application <input type="checkbox"/> New Group Plan <input type="checkbox"/> Life Event/Date _____ <input type="checkbox"/> Status Change _____ <input type="checkbox"/> Dependent Add/Delete <input type="checkbox"/> Change Name/Address <input type="checkbox"/> Other _____	<input type="checkbox"/> New Hire <input type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> Late Enrollee	Employee Type (Check all that apply)
Position/Title			<input type="checkbox"/> Active <input type="checkbox"/> COBRA/State Continuation Start dt ___/___/___ End dt ___/___/___
Hours Worked per week			<input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired
Salary \$ _____ Required only if Life Plan based on salary			<input type="checkbox"/> Other _____

**A. Employee Information**

Last Name		First Name		MI	Social Security Number		Home Phone	Work Phone
Address			Apt #	City	State	Zip Code	Email Address	
Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Height	Weight	Used tobacco in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		Language preference, if not English		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Physician* (First & Last Name)/ ID #			Primary Care Dentist (First & Last Name)/ ID #			

**B. Family Information**

List All Enrolling (Attach sheet if necessary)

Last Name	First Name	MI	Sex	Relationship**	Birthdate	Height	Weight	Full Time Student	Physician* (Name/ID#)	Tobacco Used
Social Security Number									Primary Care Dentist (Name/ID#)	
			M	Spouse						<input type="checkbox"/> Yes <input type="checkbox"/> No
			F							
			M	Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			F							
			M	Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			F							
			M	Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			F							

\*IMPORTANT: Please use the UnitedHealthcare directory of providers to choose a Primary Physician (Primary Care) for yourself and each of your covered dependents, for UnitedHealthcare Select, Select Plus, and other products requiring a Primary Physician designation only. \*\*For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on a separate sheet.

**C. Product Selection**

Please check all that apply. Benefit offerings are dependent upon employer selection.

Dual Option Plan Selected

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Medical	Dental
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Dependents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

Life Insurance Beneficiary's Full Name and Address

Relationship

Coverage Provided by "UnitedHealthcare and Affiliates":

Medical coverage provided by United HealthCare Insurance Company or United HealthCare of the Midwest, Inc.

Dental coverage provided by United HealthCare Insurance Company or United HealthCare of the Midwest, Inc. or Dental Benefit Providers of Illinois, Inc.

Life Insurance coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company

Vision coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company

# 2012 Plan Year

## D. Prior Medical Insurance Information

This section must be completed to receive credit for prior medical coverage.

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?

NO  YES (if yes, please complete this section.)

Prior medical carrier name \_\_\_\_\_ Effective date \_\_\_/\_\_\_/\_\_\_ End date \_\_\_/\_\_\_/\_\_\_

Prior coverage type:  Employee  Spouse  Child(ren)  Family

## E. Other Medical Coverage Information

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

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare?  YES (continue completing this section)  NO (skip the rest of this section)

Name of other carrier \_\_\_\_\_

Other Group Medical 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 for other coverage
Employee:				
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

\*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (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.

Medicare – Employee Information: If enrolled in Medicare, 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)\*\*

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 \_\_\_/\_\_\_/\_\_\_

Medicare – Spouse/Dependent Name: \_\_\_\_\_

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)\*\*

Reason for Medicare eligibility:  Over 65  Kidney Disease  Disabled  Disabled but actively at work

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

\*\* If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

## F. Medical History

Employee Name \_\_\_\_\_ SSN \_\_\_\_\_ Group Name \_\_\_\_\_

Has anyone on this application consulted with or been examined or treated by any health care professional during the last 10 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below. I understand the purpose of the disclosure and use of my information is to allow The Company and Affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. **Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective.**

<b>1 Cancer</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Melanoma <input type="checkbox"/> Other _____ <input type="checkbox"/> Testicular <input type="checkbox"/> Brain <input type="checkbox"/> Ovarian <input type="checkbox"/> Cervical <input type="checkbox"/> Prostate Stage _____
<b>2 Heart/Circulatory</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Aneurysm <input type="checkbox"/> Bypass <input type="checkbox"/> Angioplasty/Stent <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Elevated Cholesterol/Triglycerides <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Angina <input type="checkbox"/> Hemophilia <input type="checkbox"/> Blood Clots <input type="checkbox"/> Pacemaker <input type="checkbox"/> Blood Disorder <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Other _____
<b>3 Reproductive</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Pregnancy (due date _____) <input type="checkbox"/> Multiples (# _____) <input type="checkbox"/> Pregnancy Complications <input type="checkbox"/> Fibroids <input type="checkbox"/> Menstrual Disorders <input type="checkbox"/> Breast Disorders <input type="checkbox"/> Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Other _____
<b>4 Intestinal/Endocrine</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chronic Pancreatitis <input type="checkbox"/> Colon Disorder <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis B/C <input type="checkbox"/> Reflux <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Ulcer <input type="checkbox"/> Growth Hormones <input type="checkbox"/> Other _____
<b>5 Brain/Nervous</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Tumor <input type="checkbox"/> Head Injury <input type="checkbox"/> Cyst <input type="checkbox"/> Other _____
<b>6 Immune</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Scleroderma <input type="checkbox"/> ALS <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Psoriasis <input type="checkbox"/> AIDS <input type="checkbox"/> HIV+ <input type="checkbox"/> Lupus <input type="checkbox"/> Immuno Deficiency <input type="checkbox"/> Other _____ Please note: For AIDS and HIV, you are only required to check yes if you or any person listed in Section B "Family Information" on the front of this form, has been diagnosed with AIDS or HIV.
<b>7 Lung/Respiratory</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Lung Disorders <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other _____

# 2012 Plan Year

## F. Medical History (continued)

<b>8 Eyes/Ears/Nose/Throat</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> Cataracts <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Deviated Septum <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinopathy <input type="checkbox"/> Other _____
<b>9 Urinary/Kidney</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chronic Kidney Stones <input type="checkbox"/> Kidney Disorders <input type="checkbox"/> Bladder Disorders <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Prostate Disorder <input type="checkbox"/> Renal Failure <input type="checkbox"/> Other _____
<b>10 Bones/Muscles</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Bulging/Herniated Disc <input type="checkbox"/> Joint injury <input type="checkbox"/> Fibromyalgia/CFS <input type="checkbox"/> Shoulder Disorder <input type="checkbox"/> Knee Disorder <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Back Disorder <input type="checkbox"/> Neck Disorder <input type="checkbox"/> Other _____
<b>11 Behavioral Health</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> ADHD <input type="checkbox"/> Bipolar/Manic Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Autism <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Inpat ETOH/Drug <input type="checkbox"/> Inpat MH Hosp <input type="checkbox"/> Other _____
<b>12 Transplant</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bone Marrow <input type="checkbox"/> Organ <input type="checkbox"/> Discussed Possible Future Transplant <input type="checkbox"/> Stem Cell <input type="checkbox"/> Transplant Complications Year _____ <input type="checkbox"/> Other _____
<b>13 Medication</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Medications Please List Meds _____ <input type="checkbox"/> Medications Taken Within The Past Year Please List Meds _____
<b>14 Other</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Abnormal Test Or Physical Results <input type="checkbox"/> Condition Not Mentioned Above <input type="checkbox"/> Treatment Or Surgery Discussed Or Advised <input type="checkbox"/> Pending Test Results <input type="checkbox"/> Inpat Hosp/Surg in Past Yr. <input type="checkbox"/> Pending w/c claim <input type="checkbox"/> Tests Advised or Recommended <input type="checkbox"/> Refer to Specialist <input type="checkbox"/> Disability

Please give details below (If additional space is required, please attach a separate sheet and be sure to date and sign that sheet)

Question #	Person	Condition/Diagnosis	Treatment/Meds	Physician's Name	Dates Treated	Prognosis

<b>G. Waiver of Coverage</b> I decline all coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Children <input type="checkbox"/> Myself and all dependents	Declining coverage due to existence of other coverage: <input type="checkbox"/> Spouse's Employer's Plan <input type="checkbox"/> Individual Plan <input type="checkbox"/> Covered by Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> COBRA from Prior Employer <input type="checkbox"/> VA Eligibility <input type="checkbox"/> Tri-Care <input type="checkbox"/> I (we) have no other coverage at this time <input type="checkbox"/> Other _____	I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.
	Date	Employee Signature if waiving coverage

<b>H. Signature</b> I authorize United HealthCare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my information is to allow UnitedHealthcare and Affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.  I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that UnitedHealthcare and Affiliates 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. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card. Please maintain a copy of this authorization for your records.		
Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)

# 2012 Plan Year

## I. Census Information (optional)

NOTE: Responding to this question is optional and is not required. 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     American Indian/Alaska Native     Asian  
    Native Hawaiian/Pacific Islander     Other Race, please specify \_\_\_\_\_
- 
2. Are you of Hispanic or Latino origin?     Yes     No
-

## 2012 Plan Year

By completing this application:

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the medical history, condition or treatment of any person named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for medical coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date of this application. I (we) know that I (we) have the right to ask for and receive a copy of this authorization.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding my coverage may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the application. I (we) understand that the HMO/insurance company(ies) 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 the application and any attachments.

I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card.

### **Confidentiality**

Make sure your employer has completed the “To be completed by the employer” section of the enrollment form before you begin to complete your portion of the form. If you do not wish to disclose personal medical information through this form to anyone other than UnitedHealthcare and its affiliates and representatives for underwriting and other purposes permitted by law, you may complete all information on the enrollment form, then insert and seal the form in an envelope before returning it to your employer or broker.



## Your rights and responsibilities



# Important information

In order to make choices about your coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete, and we urge you to contact us if the information in your Summary Plan Description, Certificate of Coverage or other materials does not answer your questions. Further information is available at [myuhc.com](http://myuhc.com)<sup>®</sup>.

1. We do not provide medical services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
  - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
  - We do not decide what care you need or will receive. You and your physician make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
4. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do

we have a right to control your physician's treatment or plan.

5. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements to you. If they do not, we encourage you to talk to your physician about these arrangements.
6. We encourage physicians to talk with you about medical care you or your physician think might be valuable.

### Pre-existing conditions

If you or your covered dependents have received medical advice, care or treatment for an injury or sickness before beginning coverage or a waiting period under your health plan that injury or sickness may be considered a pre-existing condition.

Under federal law, a group health plan may look back for a period up to six months prior to the date coverage begins or, if earlier, the date a waiting period begins to determine if a pre-existing condition exists. A group health plan may exclude benefits for pre-existing conditions for up to 12 months (18 months for late entrants) from the above date. Pregnancy is not a pre-existing condition. A pre-existing condition will not apply to a newborn child, adopted child or a child placed for adoption prior to age 18, if the child is enrolled in a plan within 30 days of birth, adoption or placement for adoption. Genetic information is not considered a pre-existing condition unless there is a specific diagnosis related to the information.

Under federal law, a group health plan must reduce a pre-existing condition exclusion period by the same number of days you or your dependents were covered under prior health plans, unless there has been a significant break in coverage. If you or your dependents have a break in coverage of 63 or more days (including a newborn child, adopted child or child placed for adoption), coverage under prior plans will not be used to reduce a pre-existing condition exclusion period. In determining whether there has been a break in coverage of 63 days or more, plans may not include a waiting period you or your dependents may have had to satisfy. To receive credit for coverage under prior health plans (and thereby reduce or eliminate any pre-existing condition exclusion), you must show proof of prior coverage. You have the right to request a Certificate of Prior Creditable coverage from your prior employer or insurer. If necessary, UnitedHealthcare will help you obtain this information.

### Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage

I understand that I am completing a joint life and health application and that each response must be complete and accurate.

I (we) request the indicated group medical and/or life coverage for myself and, if the plan provides, for my dependents.

I authorize any required premium contributions to be deducted from earnings.