

EXHIBIT 12B – DPPO Plan Summary

United Healthcare

Voluntary Options PPO/covered dental services

dental plan
Custom /U85

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Calendar Year Deductible	\$50	\$50	\$0	\$0
Family Annual Calendar Year Deductible	\$150	\$150	\$0	\$0
Maximum (the sum of all Network and Non-Network benefits will not exceed annual maximum)	\$1500 per person per Calendar Year	\$1500 per person per Calendar Year	\$1000 per person per Lifetime	\$1000 per person per Lifetime
New enrollee's waiting period:	None		None	
Annual deductible applies to preventive and diagnostic services			No (In Network) No (Out Network)	
Annual deductible applies to orthodontic services			Yes	
Orthodontic eligibility requirement			Adult & Child	
COVERED SERVICES*	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES	
DIAGNOSTIC SERVICES				
Periodic Oral Evaluation	100%	100%	Limited to 2 times per calendar year.	
Radiographs	100%	100%	Bite-wing: Limited to 1 series of films per Calendar Year.	
Lab and Other Diagnostic Tests	100%	100%		
PREVENTIVE SERVICES				
Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per calendar year.	
Fluoride Treatment (Preventive)	100%	100%	Limited to Covered Persons to age 19 years, and limited to: 4 treatments of topical application of sodium fluoride per lifetime, 1 treatment of topical application of stannous fluoride per calendar year, 1 treatment of application of acid fluoride phosphate per calendar year.	
Space Maintainers	100%	100%	For missing primary teeth.	
Emergency Palliative Treatment	100%	100%	Covered as a separate benefit only if no other service was done during the visit other than X-rays.	
BASIC SERVICES				
Radiographs	80%	80%	Complete/Panorex: Limited to 1 time per consecutive 36 months.	
Restorations (Amalgam or Anterior Composite)*	80%	80%	Multiple restorations on one surface will be treated as a single filling.	
General Services	80%	80%	General Anesthesia: When medically indicated and administered in connection with Oral Surgery by a physician other than the operating dentist. Local Anesthesia and I.V. Sedation: For covered Oral Surgery	
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.	
Oral Surgery (includes surgical extractions)	80%	80%		
Periodontics	80%	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 4 times per calendar year provided there is presence of periodontal disease in the 24 months prior to such treatment.	
Endodontics	80%	80%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.	
Repair of damaged crowns, inlays, onlays, bridgework or dentures	80%	80%	Limited to once every 3 years	
MAJOR SERVICES				
Inlays/Onlays/Crowns*	50%	50%	Limited to 1 time per tooth per consecutive 60 months.	
Dentures and other Removable Prosthetics	50%	50%	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%	50%	Once per tooth per consecutive 60 months.	
ORTHODONTIC SERVICES				
Diagnose or correct misalignment of the teeth or bite	50%	50%	Treatment may not exceed 2 years from the beginning date of such treatment. Payment spread over the course of the treatment and ceases upon termination of coverage.	

* 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.

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.

UnitedHealthcare/Dental Exclusions and Limitations

General Limitations

PERIODIC ORAL EVALUATION Limited to 2 times per calendar year.

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to one time per consecutive 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.

FLUORIDE TREATMENTS Limited to Covered Persons to age 19 years.

SPACE MAINTAINERS Limited to primary teeth.

SEALANTS Not covered

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 For covered Oral Surgery only.

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 4 times per calendar year provided there is presence of periodontal disease in the 24 months prior to such treatment.

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 1 time per 3 years.

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 When medically indicated and administered in connection with Oral Surgery by a physician other than the operating dentist .

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:

- Charges or services furnished or paid by reason of past or present service in the armed forces of any government, including, without limitation, any dental treatment which is provided in a veteran's hospital, military hospital, or other institution operated by the United States government of by any foreign government.
- dental treatment received from a dental or medical department maintained by the Policyholder, a mutual benefit association, labor union, trustee, or similar type of group.
- dental treatment required as a result of intentionally self-inflicted injury, war, or engaging in a riot or insurrection.
- broken appointments or the completion of claim forms or pre-treatment forms required by Contractor.
- dietary planning, plaque control, oral hygiene instruction, congenital or developmental malformation existing when the person became covered under this Policy, or sealants.
- the replacement of lost, missing, or stolen prosthetic devices.
- any dental treatment which could have been rendered at a lower cost by means of any reasonable substitute that constitutes a generally accepted dental practice shall be included only to the extent of the cost of the lower cost substitute.
- installation of an initial prosthodontics appliance when such charges are incurred for replacement of a congenitally missing tooth or teeth or replacement of a tooth or teeth all or any of which were lost while the individual was not covered by the Policy;
- replacement of an existing prosthodontics appliance unless;
 - necessitated by the extraction of additional natural teeth while covered under this Policy, or
 - the existing appliance is at least five (5) years old and cannot be made serviceable and twelve (12) months have elapsed since the effective date of coverage, or
 - the replacement appliance is made necessary as the result of an initial placement of an opposing denture while covered.
- any expenses incurred for treatment rendered after the date of termination of an individual's coverage, except as specified in Subsection 5 of Section IV of the Policy.
- any expenses incurred for treatment rendered for any occupational disease or accident.
- any care, services, supplies or treatment rendered on an experimental or research basis not recognized as a generally accepted dental practice.
- any expenses in excess of the usual and customary charge for the service or supply.
- treatment other than by a duly licensed dentist, physician, dental hygienist, technician or laboratory unless performed by or under the direction of a dentist or physician.
- any supply or service that is not reasonably necessary for the dental care of the Covered Person.
- any care or services for which the provider customarily makes no charge.
- any care or service rendered by a member of the Covered Person's family or close relative, including a person related by blood or marriage to the Covered Person.
- any care or services covered in whole or in part under the Policyholder's medical plans, regardless of whether the Covered Person holds coverage thereunder, or not.
- temporary restorations; however, if temporary restoration is part of a course of treatment, the maximum benefit for a permanent restoration shall include the fee for temporary restoration.
- any duplicate prosthetic device or any other duplicate appliance.
- implantology.
- treatment except as orthodontic services, for placement of bands and regular maintenance of braces, the result of:
 - mandibular or maxillofacial surgery to correct growth defects, jaw disproportions or malocclusions, except for correction of a congenital anomaly in a Child who was covered under this Policy from birth, or
 - Appliances or restorations used solely to increase vertical dimension, reconstruct occlusion or correct or treat temporomandibular joint dysfunction or TMJ pain syndromes, or
 - Any changes due to temporomandibular joint disorder or dysfunction, or
 - Diagnostic x-rays, exams and any other course of treatment to relieve TMJ pain syndrome.
- charges for care or treatment of occlusion by adjustment, appliance, or restorations, except for orthodontics.
- any expense incurred prior to becoming covered or any dental work in progress at the time a patient becomes covered under this Policy.
- any charges in excess of the charge customarily made when alternate services or supplies are customarily available for such treatment, beyond the charge for the least expensive service or supply resulting in professionally adequate treatment.
- services and supplies that are cosmetic in nature, including charges for personalization or characterization of dentures; without limitation, facings on crowns and pontics posterior to the second bicuspid shall always be considered cosmetic.
 - periodontal splinting, or
 - charges for drugs or their administration, except as specifically allowed,
 - hospitalization for any procedure