Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: UnitedHealthcare Insurance Company

Plan Name: UHC Standard Plan 1P163 (D0016548)

Policy Type: PPO

Insurer Phone #: 1-800-445-9090

Effective Date: 8/1/2025

Insurer Website: www.myuhc.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE INSURER WEBSITE AT www.myuhc.com OR CALL 1-800-445-9090.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network		Out-of-Network	
Dental	Per Individual:	$50	Per Individual:	$50
	Per Family:	$150	Per Family:	$150

- **The deductible applies to all services except Preventive, Diagnostics, Ortho (if on plan design).**
- A **deductible** is the amount you are required to pay for covered dental services each policy year before the insurer begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your insurer for alternative rates of payment for dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that have not contracted with your insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	$1,500	$1,500
Lifetime Maximum for Orthodontia	$1,500	$1,500

- **Annual maximum** is the maximum dollar amount your policy will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period.
- **Lifetime maximum** means the maximum dollar amount your policy providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits for all or certain dental treatments.

Category	Waiting Period
Diagnostics	No Waiting Period
Preventive	No Waiting Period
Minor Restorative	No Waiting Period
Oral Surgery	No Waiting Period
Endodontics	No Waiting Period
Periodontics	No Waiting Period
Crowns	No Waiting Period
Dentures	No Waiting Period
Ortho	No Waiting Period

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Diagnostics	100%	100%	2-F-12M (i - ii - iii)*
Bitewing X-ray	Diagnostics	100%	100%	1-P-1Y
Cleaning	Preventive	100%	100%	2-F-12M
Filling	Minor Restorative	80%	80%	999- -0M
Simple Extraction	Oral Surgery	80%	80%	1-F-99Y
Root Canal	Endodontics	80%	80%	1-F-99Y

Scaling and Root Planing	Periodontics	80%	80%	1-F-24M
Ceramic Crown	Crowns	50%	50%	1-F-60M
Removable Partial Denture	Dentures	50%	50%	1-F-60M
Orthodontia	Ortho	50%	50%	999- -0M

* i-ii-iii Definition: i = Number of Procedure (999 = unlimited); ii = Procedure Frequency Type (C=Calendar Year, F=Floating, P=Plan Year); iii = Period and Timeframe (D=Day, M=Month, Y=Year) - Example: 1-F-36M read as 1 Procedure per 36 Floating Months

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT.

The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this policy to other dental policies you may be considering. Your actual cost will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	Sam Needs a Tooth Filled	Maria Needs a Crown
New patient exam, x-rays (FMX) and cleaning	Resin-based composite - one surface, posterior	Crown - porcelain/ceramic substrate

Dana's Visit	**Dana's Visit**	**Sam's Visit**	**Sam's Visit**	**Maria's Visit**	**Maria's Visit**
Total Cost of Care	In-network: $250 Out-of-network: $450	Total Cost of Care	In-network: $150 Out-of-network: $250	Total Cost of Care	In-network: $950 Out-of-network: $1,400
Deductible	In-network: Per Indiv: $50 Per Family: $150 Out-of-network: Per Indiv: $50 Per Family: $150	Deductible	In-network: Per Indiv: $50 Per Family: $150 Out-of-network: Per Indiv: $50 Per Family: $150	Deductible	In-network: Per Indiv: $50 Per Family: $150 Out-of-network: Per Indiv: $50 Per Family: $150
Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: $1,500	Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: $1,500	Annual Maximum (Plan Will Pay)	In-network: $1,500 Out-of-network: $1,500
Patient Cost (copayment or coinsurance)	In-network: 0% Out-of-network: 0%	Patient Cost (copayment or coinsurance)	In-network: 20% Out-of-network: 20%	Patient Cost (copayment or coinsurance)	In-network: 50% Out-of-network: 50%
In this example, Dana would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: $50 Out-of-network: $50	In this example, Sam would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: $70 Out-of-network: $90	In this example, Maria would pay (includes copays/ coinsurance and deductible, if applicable):	In-network: $500 Out-of-network: $725
Summary of what is not covered or subject to a limitation:	2-F-12M	Summary of what is not covered or subject to a limitation:	Reimbursed as Amalgam	Summary of what is not covered or subject to a limitation:	1-F-60M