UnitedHealthcare

Barbeque Integrated DBA Smokey Bones

Dental PPO Plan

Voluntary Options PPO/covered dental services

Custom P8341/U80

	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:		
Annual deductible applies to preventive and diagnostic services		No (In Network) No (Out Network)
Annual deductible applies to orthodontic services		No
Orthodontic eligibility requirement		Child (up to age 19)

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 2 series of films per Calendar 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 19 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%	Limited to 1 per consecutive 60 months, adult & child.
BASIC SERVICES			
Restorations (Amalgam or Anterior Composite)*	75%	75%	Multiple restorations on one surface will be treated as a single filling.
Emergency Treatment / General Services	75%	75%	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	75%	75%	Limited to 1 time per tooth per lifetime.
Oral Surgery (includes surgical extractions)	75%	75%	
Periodontics	75%	75%	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	75%	75%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
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%	Course of treatment is typically 24 months, with the initial payment at banding of 20% and remaining payment spread over the course of the treatment

This plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future 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 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 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.

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 2 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 19 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 1 per consecutive 60 months, adult & child. 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:

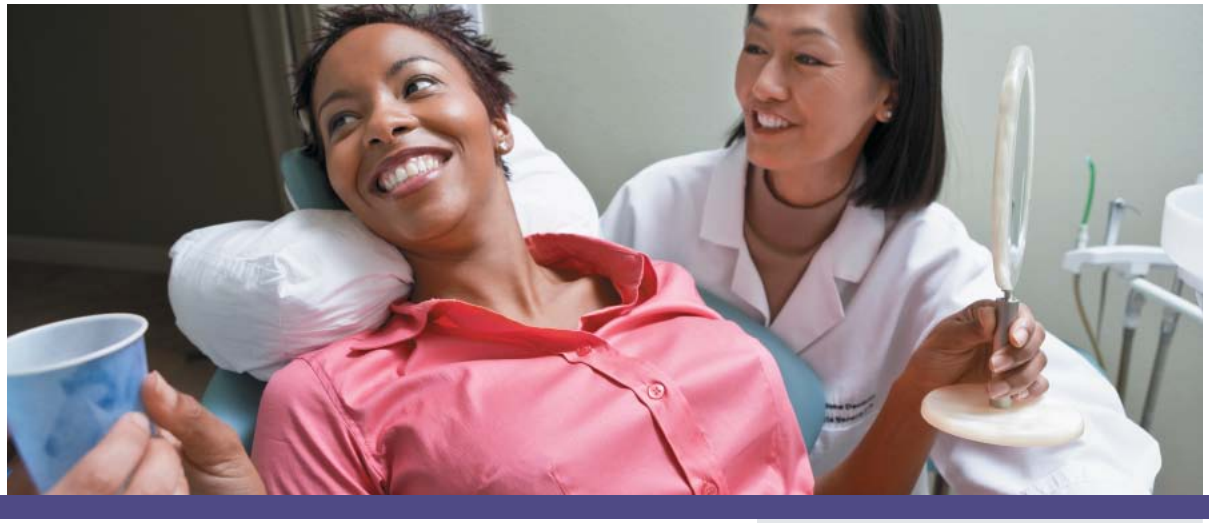
1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery 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.

Dental

Annual Maximum $1,500

Features and benefits

Consumer MaxMultiplier® Rollover Benefit



Getting regular dental checkups is key to maintaining healthy teeth and gums. And with the Consumer MaxMultiplier Rollover Benefit from UnitedHealthcare dental, you can earn award dollars for getting regular checkups.[1] If you have family members covered by your plan, each family member can earn his or her own awards. And you can roll your awards over from one year to the next.

How the program works.

1. Visit your dentist at least once during the benefit year.
2. At the end of the benefit year, if the dollar amount of the dental claims paid for you is less than your plan's annual claim threshold, you earn an annual account award.[2]
3. If all your claims for the year were for in-network providers, you'll earn a $100 annual network bonus.[3]
4. Your annual account award will be added to your annual maximum for the following benefit year. The combined total will be the maximum benefit for dental claims that year.

In brief:

- Consumer MaxMultiplier rewards you for getting preventive care
- You can earn award dollars to use for future dental claims
- The number of award dollars is determined by the out-of-network maximum of your dental benefit plan
- You can roll award dollars over from year to year

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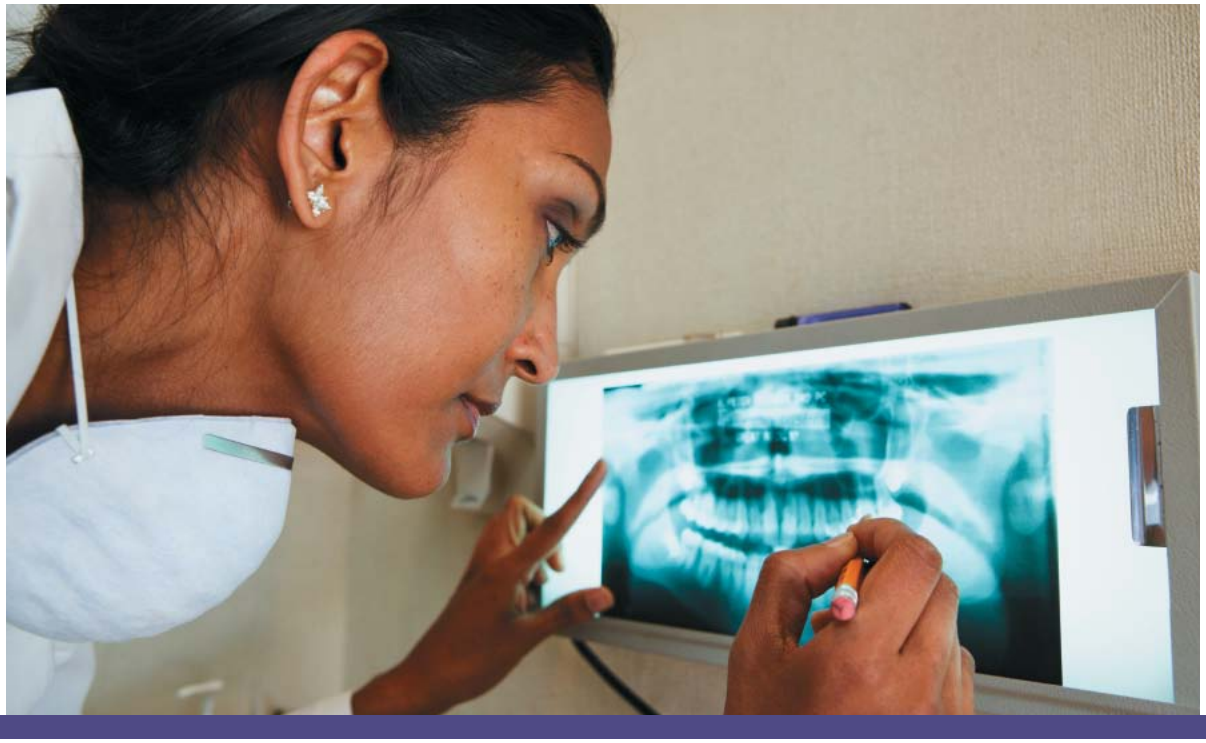
Example.

The chart below shows the award dollars you could earn if your plan had an original annual maximum of $1,500.

Here's how your Consumer MaxMultiplier Rollover Benefit adds up:	
IF your original annual maximum is:	**$1,500**
AND the total dental claims paid for you in one year is less than this: *(This is the plan's annual claim threshold.)*	$750
THEN you qualify for an annual account award of:	$400
PLUS, if all your claims for the year are for network providers, you could also earn[3]: *(This is the annual network bonus.)*	+ $100
THEREFORE, the potential total Consumer MaxMultiplier earnings for the year are: *(This amount is added to your annual maximum for the following year.)*	= $500[4]

Consumer MaxMultiplier terms.

- **Original annual maximum:** The maximum amount the plan will pay for a member's claims during the plan year
- **Annual claim threshold:** A set amount determined by the plan. A member's paid claims must fall below this amount to qualify for a Consumer MaxMultiplier award
- **Annual account award:** The dollar amount a member earns when their annual claims are greater than $0, but lower than the annual claim threshold
- **Annual network bonus:** The $100 a member earns when their claims for the plan year are all for network providers[3]
- **Account limit:** The maximum balance a member can have in their account



How your awards are used.

- Your account awards are used to pay for claims that go beyond your original annual maximum
- If you don't use your entire award balance, you can carry over the difference from year to year
- Awards can be used for claims that you file up to 180 days after your benefit period ends
- Awards can be used for both network and non-network claims
- Award balances do not apply to orthodontic services

If you don't submit any claims during the benefit period, you won't earn any new awards. Some additional limitations apply. When you become a member, you can call the Customer Care number on the back of your card for complete details.

Some things to remember.

- **If you become a member** of a UnitedHealthcare dental plan in the last three months of a benefit period, you will have to wait until the end of the first full month of the next benefit period to participate in Consumer MaxMultiplier
- **If you end your benefit coverage,** but return within six months with the same employer, you can rejoin Consumer MaxMultiplier without losing any previously unused award balance if your employer still offers a dental plan with Consumer MaxMultiplier. However, if six months or more pass, or if your employer changes, your award balance is no longer available
- **If your employer decides to change your dental plan,** your award balance will move with you as long as the new plan includes Consumer MaxMultiplier. If the new plan does not, you will lose your award balance

One more reason to choose UnitedHealthcare.

Consumer MaxMultiplier is just one more benefit you enjoy with a dental plan from UnitedHealthcare. With the added value it provides, Consumer MaxMultiplier encourages better oral health, which is connected to better health overall.

For more information about Consumer MaxMultiplier, members can call the Customer Care number on the back of their card.

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[1]Members will not actually earn cash that they can access or withdraw. UnitedHealthcare adds the award dollars to your annual maximum for the following year and applies them to qualifying claims.

[2]If your plan has different network versus non-network maximums, we base the awards on the non-network maximum.

[3]Applies to PPO plans only.

[4]If your plan has an annual maximum of $1,500, then $1,500 is the maximum balance you can have in your Consumer MaxMultiplier Rollover Benefit account.

UnitedHealthcare Dental® coverage underwritten by UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOLO6. TX and associated COC form number DCO.CER.06.

UnitedHealthcare Insurance Company

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