

**Thank you for your interest in the Georgia State Lodge FOP
Endorsed Dental and Vision Plans.**

Enclosed you will find enrollment forms, highlights of the plans, and payment information. Members have the option of enrolling in the dental plan only, the vision plan only or both the dental and vision plans.

Be sure to fill in the forms completely. If you have questions while you are completing the forms contact the Doyle Rowe LTD Enrollment Hotline at 1-866-201-2524.

Choose your payment option. Monthly premiums are as follows:

	Dental Only	Vision Only	Both
Single	\$35.01	\$5.53	\$40.54
Single + One	\$68.08	\$13.79	\$81.87
Family	\$110.91	\$13.79	\$124.70

You may pay your premium via monthly bank draft or quarterly, semi-annual or annual check. If you choose to pay your premiums using a check, you must supply either Visa or Mastercard information as well. Your credit card will only be charged if your payment is not received by the 15th of the month in which it is due. If you choose to remit payment via quarterly, semi-annual or annual check please include your first payment. You will be billed 30 days before your next payment is due. **Please make checks payable to: Doyle Rowe LTD.** Be sure to write FOPUHC on the memo line. Bank drafts or credit card payments will appear as a payment made to Doyle Rowe LTD on your bank or credit card statement.

Applications received by the 20th of each month will become effective on the first of the next month, those received after the 20th will become effective on the first of the month following the next month, e.g. forms received on May 19 will become effective on June 1, those received on May 21 will become effective on July 1. Remember a one year enrollment is required.

You may visit www.myuhcvision.com to locate a provider, track claim status, trace an order or obtain answers to frequently asked questions.

Or
www.myuhcdental.com to find an in network dentist. Simply click the “dentist locator,” select Options PPO and enter your zip code. You may also track claim status, and access cost estimate tools using this site.

Please return your completed forms to:

**Doyle Rowe LTD
105 S. York Street, Suite 230
Elmhurst, IL 60126**

Again, please direct your questions to Doyle Rowe LTD at 1-866-201-2524.

United Healthcare Dental and Vision are privileged to offer benefits to the members of the Georgia State Lodge FOP. We look forward to providing you with quality, affordable dental and vision plans.



Premium Payment Option and Authorization

Last Name	First Name	Middle Initial	
Street	City	State	Zip
Phone	Fax	E-mail	

Payment Option (Select One)

A. Financial Institution Debit Authorization - membership premium deducted from bank account:

Monthly Electronic Fund Transfer Type: Checking Savings

Account Holder Name: _____

Bank Account Number: _____

Bank Routing Number: _____

Account Owner Signature (if different than applicant) _____

B. Membership premium to be billed to my home address (select one). Make checks payable to Doyle Rowe LTD

Quarterly (first quarter premium enclosed)

Semi-Annually (first six months premium enclosed)

Annually (first years premium enclosed)

Those choosing to pay by check must supply a credit card number. Credit cards will *not* be charged unless payment is not received by the 15th of the month in which payment is due.

Credit Card Type (select one): Visa Mastercard

Name (as it appears on the card) _____

Credit Card Number _____

Expiration Date _____ / _____
Month/Year

I hereby authorize Doyle Rowe LTD to accept payment by monthly bank draft or quarterly, semi-annual or annual check for the plan(s) I have chosen to enroll in using a separate enrollment form. I understand that if I choose to pay by check, a valid credit card must remain on file and will be charged in the event that payment is not received within 15 days of the due date. I hereby authorize Doyle Rowe LTD to make recurring charges to the credit card listed above. This authority will remain in effect for a period of not less than one year from the effective date of coverage and thereafter until cancelled by written notice to Doyle Rowe LTD from me.

Signature

Date

	NON-ORTHODONTICS			
	NETWORK	NON-NETWORK		
Individual Annual Calendar Year Deductible	\$50	\$50		
Family Annual Calendar Year Deductible	\$150	\$150		
Maximum (the sum of all Network and Non-Network benefits will not exceed annual maximum)	\$1000 per person per Calendar Year	\$1000 per person per Calendar Year		
New enrollee's waiting period:				
Annual 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 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 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 (Amalgams or Composite)	80%	80%	Multiple restorations on one surface will be treated as a single filling.	
General Services (incl. Emergency Treatment)	80%	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	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 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement	
Endodontics	80%	80%		
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.	

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 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 Paronex Radiograph if taken for diagnosis of molars, Cysts or neoplasms

BITEWING RADIOGRAPHS Limited to 1 series of films per CalendarYear

EXTRAORAL RADIOGRAPHS Limited to 2 films per CalendarYear

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.

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 prescribed 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.

A Dental plan that's easy to chew

Taking good care of your teeth is an important part of maintaining your overall health. That's why UnitedHealthcare Dental wants to make keeping your mouth healthy as easy as possible.

If you enroll in the UnitedHealthcare Dental program, these are some of the benefits you will receive:

- ▶ Access to an extensive national network of dentists
- ▶ Ability to visit any specialist you want without a referral
- ▶ No paperwork*
- ▶ Preventive care, including exams and cleanings, at little or no out-of-pocket cost
- ▶ **Up to 30% savings** on services from network dentist
- ▶ Freedom to choose a non-network dentist
- ▶ Access to the only claims cost calculator on the market today that can determine exact out of pocket expenses based on your plan.
- ▶ Easy access to your benefit information at myuhcspecialtybenefits.com

* No claim forms for in-network services

Enroll today to receive this important benefit. For more information about your dental insurance options, refer to your benefits summary.

For more information visit us at myuhcspecialtybenefits.com

UnitedHealthcare Specialty Benefits unites health and financial well-being for individuals and organizations, through integrated and personally relevant products, services and technologies. We offer a broad array of specialty insurance products. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by UnitedHealthcare Insurance Company, United HealthCare Services, Inc. or their affiliates. All products may not be available in all states. UnitedHealthcare Specialty Benefits is a brand of UnitedHealth Group.

With a UnitedHealthcare Dental plan you can save money and invest in a healthy smile to last a lifetime. Here's how:

Annual cost comparison

Covered participants	Dental services	Average cost without a dental plan	Cost with our dental plan	Savings with our dental plan
Employee	Semiannual exams, cleanings, and x-rays. One filling, One root canal	\$1,195	\$453	\$742
Employee and Spouse	Semiannual exams, cleanings, and x-rays. Two fillings, One root canal	\$1,580	\$666	\$914
Employee and Family (Spouse and two children)	Semiannual exams, cleanings, and x-rays. Two fluoride treatments, four fillings, One root canal	\$2,344	\$909	\$1,435

Enroll today to receive this important benefit. For more information about your dental insurance options, refer to your benefits summary.

* Average cost without a dental plan are based upon national average 'Usual and Customary' rates published by Ingenix.

** Costs with the voluntary plan include: national average tax-adjusted (20% pre-tax discount) premiums which are 100% paid by employee, national average coinsurance amounts, and annual deductible. Coinsurance costs for the voluntary dental plan are based on network utilization of a 100/80/50 plan design with a \$50/\$150 annual deductible. Premiums will vary upon geographic region, total group enrollment in plan, and group demographic factors.



UnitedHealthcare Dental Enrollment Form

SOCIAL SECURITY NUMBER		NAME, LAST		FIRST		MI	
ADDRESS			CITY		STATE	ZIP	
TELEPHONE NUMBER						<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married	
Home ()		Work ()					
APPLICANT'S DATE OF BIRTH		EMPLOYER OR GROUP NAME					
PLAN COVERAGE		<input type="checkbox"/> Single		<input type="checkbox"/> Single + Spouse		<input type="checkbox"/> Single + Child(ren)	
						<input type="checkbox"/> Family	

UnitedHealthcare Dental Options PPO Plan

UnitedHealthcare Dental Managed Indemnity Plan

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	
				<input type="checkbox"/> Husband	<input type="checkbox"/> Wife
				<input type="checkbox"/> Son	<input type="checkbox"/> Daughter
				<input type="checkbox"/> Son	<input type="checkbox"/> Daughter
				<input type="checkbox"/> Son	<input type="checkbox"/> Daughter
				<input type="checkbox"/> Son	<input type="checkbox"/> Daughter

FOR INTERNAL USE ONLY

Employer Authorization
Effective date
Type of coverage

SIGNATURE _____

I hereby understand that any coverage is limited by the benefits and exclusions of the Group Dental Agreement

MINIMUM ENROLLMENT IS ONE YEAR

The UnitedHealthcare Dental Managed Indemnity Plan and the UnitedHealthcare Dental Options PPO Plan are underwritten by United HealthCare Insurance Company, Hartford, Connecticut (except in New York) United HealthCare Insurance Company of New York, Hauppauge, New York (New York only)