



UnitedHealthcare Dental Administration Manual

UnitedHealthcare Dental®

UnitedHealthcare Dental®

Dear Valued Customer:

Welcome to UnitedHealthcare Dental®. Thank you for the opportunity to serve you and your organization. We look forward to a long and successful association.

The instructions on the following pages will guide you through the administration of your dental plan. We encourage you to familiarize yourself with this guide and keep it handy as a reference tool. If you don't find the information you need, please contact us and we'll provide it. This Manual is not a legal document. Please consult your Certificate of Coverage for details concerning the precise provisions of your benefit plan.

Our mission is to provide clients and consumers with the access to high quality dental benefits that are affordable and simple to use.

We look forward to serving you.

Sincerely,

UnitedHealthcare Dental

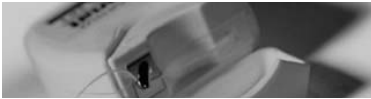


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Quick Reference Contacts and Information

• Online Information

Please visit: www.myuhcdental.com
or Employer eServices® Online:
www.employereservices.com

- Member eligibility
- Claim history
- ID card requests
- Provider search
- Specific plan or benefit information
- General dental information
- UnitedHealthcare Dental resources

• General Policy Questions

Please refer to the Key Contacts Sheet located on page 13 of this guide.

- General administration/benefit questions
- Open enrollment coordination/supplies
- Unresolved eligibility issues
- Day-to-day servicing requests
- Escalated claim questions
- Requests for additional ID cards
- Unresolved billing questions

• Member Questions

Please contact Dental Service Center at
1-877-816-3596, Weekdays 8:00 a.m. to 11:00 p.m. EST.
Saturday 9:00 a.m. to 5:30 p.m. EST.

- Eligibility
- Covered services
- Network questions
- Provider change requests
- Change of address
- ID cards
- Benefit questions

• Claims Submission

Please contact Dental Service Center at
1-877-816-3596 or Mail Claim to:

UnitedHealthcare Dental
Attn: Claims Unit
P.O. Box 30567
Salt Lake City, UT 84130-0567

Nevada groups call 1-800-926-0925
and submit claims to:
NPD
1432 South Jones Blvd.
Las Vegas, NV 89146

- Appeals
- Backup documentation

• Eligibility Updates

Please Submit to:

UnitedHealthcare Dental
Attn: Eligibility
P.O. Box 30964
Oldsmar, FL 34677

or via Overnight to:
PRIME Eligibility
4050 South 500 West
Salt Lake City, UT 84123

Fax to: (248) 733-6062
Online: Employer eServices®

- Eligibility adds, changes, and terminations

Employer eServices

We know your time is valuable, so to minimize the time you spend managing your employees' benefits administration, UnitedHealthcare Dental offers Employer eServices. The Web site, www.employereservices.com, provides a simpler, easier and better health care benefit administration tool.

Look for the Employer eServices Reference Box throughout this guide for tips on how to utilize Employer eServices to the fullest.

Some of the features offered through Employer eServices are:

- Add, terminate employees and their dependents
- Employee eligibility status inquiry
- Billing
- Customer Reporting
- Provider Network information
- Claim status inquiry
- Reinstate employees
- Change Employee Status

Call Employer eServices Helpline at 1-800-651-5465 for additional assistance.

Easy Registration

Call Employer eServices at 1-800-651-5465 to register your company and you'll receive your user ID and password via e-mail.

Because electronic transactions are delivering faster access to benefits for enrollees, and reducing billing and claims errors for customers and physicians, online billing and payment is our preferred method of operation.

Online billing offers fast service, simplified invoices, downloadable data and real-time calculations and payments.

- A reminder e-mail will be sent to you every month when your invoice is ready for your review and payment on Employer eServices.
- Click on the **Billing** tab to view, sort or download current activity, view account balance and past due aging payment history, as well as submit payments.
- If you have made eligibility changes after the original invoice was generated, you can request a new adjusted invoice.
- Elect to submit your payments **online** or through Scheduled Direct Debit. **Scheduled Direct Debit** allows payment electronically through an automatic monthly debit from a designated checking account on the due date of your invoice. To set up Scheduled Direct Debit or establish an online payment method, go to the billing section of Employer eServices and select **Edit Payment Method** in the menu bar.

If you don't have access to the online billing tool, please call customer service at **1-888-842-4571** to pay by phone or receive assistance in setting up **Scheduled Direct Debit**.

Monthly Billing Statements and Payment Procedure

Employer eService for Billing

- Simplified invoices with real-time calculations
- Email notification that online invoices are ready for viewing
- Views of current or prior activity
- Complete online remittance tasks
- Ability to request a monthly adjustment invoice to reflect eligibility changes
- Ability to remit payment via Direct Debit

Paying Paper Invoices:

If you receive a paper invoice, please pay the amount billed and do not adjust your invoice. If you remit payment by mail, please:

- Detach the Invoice Remittance page from your monthly statement.
- Attach your check.
- Mail in the enclosed envelope to the address listed on the invoice remittance.
- Clearly write your billing reference number and invoice number on the front of the check.
- Do not mail enrollment forms and/or terminations to UnitedHealthcare Dental with your remittance. Please mail them separately to the following address:

UnitedHealthcare Dental
Attn: Eligibility
P.O. Box 30964
Oldsmar, FL 34677

or via Overnight to:
PRIME Eligibility
4050 South 500 West
Salt Lake City, UT 84123

Fax to: (248) 733-6062
Online: Employer eServices®

When will I receive a Billing Statement?

Invoices are generated approximately between the 9th and 18th of each month, for the first of the month's billing. The premiums are required to be paid no later than the 30th of the month.

What does the Billing Statement Include?

Clients who have selected a list billing will receive statements that include:

- A list of each insured employee listed under the plan and premium date
- A report of adjustments made from the previous month's statement

Check your statement carefully to ensure all eligible employees are included on the statement and that the benefits are correct.

Why don't Eligibility adjustments appear on my invoice?

If we do not receive your Employee Enrollment form in time to be reflected on your current invoice, your additions or terminations will be reflected on your next invoice. Any refund, credits and back charges will appear as an adjustment on your next month's invoice. You can request an adjustment invoice at any time utilizing the features of Employer eServices billing.

Administration Guidelines

Open Enrollment and Eligibility Information

Your group has an open enrollment period. During your group's open enrollment period, each plan participant has the opportunity to add, change or drop plans or to terminate or add dependents.

Submit completed eligibility forms to:

UnitedHealthcare Dental
Attn: Eligibility
P.O. Box 30964
Oldsmar, FL 34677

or via Overnight to:
PRIME Eligibility
4050 South 500 West
Salt Lake City, UT 84123

Fax to: (248) 733-6062
Online: Employer eServices®

Renewal Information

If signed renewal confirmation is not received, continuation of payment at the renewal premium will assume your intention to renew.

Employer eServices for Enrollment

- Easily add and delete employees online as they enroll in the dental plan
- Change or delete information for employees who have a change in status

Enrollment Guidelines

Enrollment Form Submission

Utilize the Dental Enrollment Form for:

- Initial open enrollment
- Adding a new employee
- Making changes to name or address
- Adding or removing dependents
- Changing plans during open enrollment

For questions regarding electronic eligibility, please call 1-888-UHC-HLP1 (1-888-842-4571). Nevada groups call 1-800-926-9025.

Submission Requirements:

- All information must be completed in full to process the plan participant's enrollment.
- All change requests and payments must be received by the last day of the current month to be reflected on the next bill month. (For example, a change request submitted to UnitedHealthcare Dental between January 1 and 31, will be reflected on the March bill).
- Qualifying event (birth of a child, new hire, marriage, etc.) change requests are effective on the day of the event if received within 31 days of the event.
- Include your company name, policy number, plan selection, employee's signature and effective date on all forms submitted.
- Change requests must be submitted through the group/benefit administrator.
- Mail enrollment forms to:
UnitedHealthcare Dental
P.O. Box 30964
Oldsmar, FL 34677

or via Overnight to:
PRIME Eligibility
4050 South 500 West
Salt Lake City, UT 84123

Fax to: (248) 733-6062
Online: Employer eServices®

To order forms, please call 1-888-UHC-HLP1 (1-888-842-4571), Monday through Friday, 8 a.m. to 5 p.m. Eastern Standard Time. Nevada groups call 1-800-926-0925. Or, order forms by using Employer eServices online at www.employereservices.com.

Enrollment of New Hires

How to Add a New Employee

Enrollment effective date is based on the effective date on the employee's enrollment form. The benefit/group administrator should validate the effective date and wait period established by each employer group in relation to the enrollee's hire date.

Add the new employee online at:
<http://www.employereservices.com>.

If you are not enrolled in Employer eServices:

- The timeframe for processing manual forms is 12 business days.
- Complete a UnitedHealthcare Dental Enrollment Form immediately after a new employee is eligible for insurance. This serves as the basic insurance record. Fill it out completely, as UnitedHealthcare Dental may return incomplete forms.
- Keep a copy for your records.
- Fax or mail the form to UnitedHealthcare Dental.

UnitedHealthcare Dental
P.O. Box 30964
Oldsmar, FL 34677

or via Overnight to:
PRIME Eligibility
4050 South 500 West
Salt Lake City, UT 84123

Fax to: (248) 733-6062
Online: Employer eServices®

- Do not mail enrollment forms with your premium payment. This will delay processing.
- Do not mail the originals if you have faxed or emailed your enrollments.

Enrollment of Rehired Employees

Who is considered to be a rehired employee?

Any employee who returns to work after temporary termination.

How do I enroll a rehired employee?

- Complete a new Enrollment Form and include the rehire date and current information.
- Keep a copy for your records.
- Fax or mail the form to UnitedHealthcare Dental. If you are enrolled in Employer eServices you can make your changes online.
- All forms must be received within 60 days of the employee's effective date.
- Begin payroll deductions after receiving the Notice of Approval.

Fax or mail the form to:
UnitedHealthcare Dental
P.O. Box 30964
Oldsmar, FL 34677

or via Overnight to:
PRIME Eligibility
4050 South 500 West
Salt Lake City, UT 84123

Fax to: (248) 733-6062
Online: Employer eServices®

Why is the rehire date important?

The rehire date will be used to determine eligibility, unless otherwise noted in the group insurance policy.

The rehired employee may be considered a late applicant if applying for insurance more than 31 days after the date of eligibility. See Enrollment of Late Applicant administration guidelines for further details.

Enrollment of Late Applicants

Who is considered to be a late applicant?

Any employee who applies for insurance more than 31 days after the date of eligibility.

Reporting Adjustments

How do I report changes and adjustments?

Use the Enrollment Form to report any of the following changes as they occur:

- Terminations of employee benefits
- Name Change
- Marital Status Change
- Dependent Insurance Change
- Address Change
- Change in subgroup designation (if applicable)

When completing the enrollment form be sure to include company name, policy number, plan selection, employee's signature and member identification number on all forms.

- Keep a copy for your records
- Fax or mail to UnitedHealthcare Dental or use Employer eServices to make your eligibility changes on-line
- All forms must be received within 60 days of the change effective date
- Fax or mail the changes to UnitedHealthcare Dental

UnitedHealthcare Dental
Attn: Eligibility
P.O. Box 30964
Oldsmar, FL 34677

or via Overnight to:
PRIME Eligibility
4050 South 500 West
Salt Lake City, UT 84123

Fax to: (248) 733-6062
Online: Employer eServices®

- Do not mail enrollment forms with your premium payment. This will delay processing.
- Do not mail the originals if you have faxed or emailed your enrollments.

Appeals & Grievances Procedure

If an employee has been unable to resolve a problem with our Member Service department, grievance forms are available at any UnitedHealthcare Dental in-network dental office, or directly from UnitedHealthcare Dental. The employee should mail a completed grievance form to:

UnitedHealthcare Dental
Attn: Claims Unit
P.O. Box 30567
Salt Lake City, UT 84130-0567

Nevada groups call 1-800-926-0925
and submit claims to:
NPD
1432 South Jones Blvd.
Las Vegas, NV 89146

Our Appeals & Grievances department will review the complaint. If appropriate, the appeal will be reviewed by the Clinical Reviewers and/or Peer Review. A written response to the appeal will be provided within 30 days from the date the appeal is received. In some instances, further appeal may be made by the member. Additional information regarding the appeals process can be obtained by calling our Member Service department at 1-877-816-3596.

COBRA* and Cal-COBRA*

Employer COBRA Responsibility

It is to an Employer's benefit to both familiarize themselves with requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), and provide timely COBRA notifications to their eligible employees. These notices must be furnished, in a form and manner of delivery as required by law, to covered employees and their spouses at the time coverage under the Plan commences, and after what the statute defines as a "qualifying event." Failure to follow these procedures can lead to ramifications concerning COBRA's extended period of coverage, and/or fines levied against the Employer by the appropriate regulatory authorities.

Overview of Federal COBRA

The Consolidated Omnibus Budget Reconciliation Act ("COBRA") allows employees who lose their health benefits the right to choose to continue their group health benefits provided by the Plan under certain circumstances. It applies to plans in the private sector and those sponsored by state and local governments. COBRA generally requires that group health plans sponsored by employers with 20 or more employees in the prior year offer their employees and their families ("qualifying beneficiaries") the opportunity for a temporary extension of health coverage ("continuation coverage") in certain instances called a "qualifying event" where coverage under the plan would otherwise end. Qualifying events may consist of the following:

- Voluntary or involuntary termination of the covered employee's employment for reasons other than gross misconduct.
- Reduced hours of work for the covered employee.
- Covered employee becoming entitled to Medicare.
- Divorce or legal separation of a covered employee.
- Death of a covered employee.
- Loss of status as a dependent child under plan rules.

Depending on the type of qualifying beneficiary, the continuation of coverage can be for up to 18 months, or up to 36 months.

COBRA continuation coverage laws are administered by several agencies. The U.S. Departments of Labor and Treasury have jurisdiction over private-sector health group health plans. Provisions of COBRA covering state and local government plans are administered by the U.S. Department of Health and Human Services.

Cal-COBRA

Two classes of individuals can apply for Cal-COBRA coverage. The first are those individuals who come from employers with 20 or more employees who have exhausted their federal COBRA benefits and have less than 36 months of total federal COBRA coverage. Those individuals can qualify for a total of 36 months of extended health benefits under federal COBRA and Cal-COBRA combined. Those who do qualify under this exception, may receive the same benefits they had under their federal COBRA plan. However, there is an exception. If an individual had only non-medical coverage under a specialized health care service plan (stand alone dental and vision) under federal COBRA, they would not qualify to have an extension of their vision or dental benefits under the Cal-COBRA program.

The second class of eligible individuals who qualify for Cal-COBRA coverage come from small employers (i.e. 2 to 19 employees). If a "qualifying event" occurs with these employees, the employees along with their spouses and dependents are allowed to enroll in Cal-COBRA. To qualify for the 36 months of extended coverage the following must happen:

1. The employee is terminated or has had their hours reduced not due to misconduct.
2. The death of the former employee.
3. Divorce from the employee.
4. The former employee has become eligible for Medicare.
5. The dependent is no longer considered a dependent under the group plan.

If the employee qualifies for Cal-COBRA under these circumstances, stand alone dental and vision will be covered.

Employers must understand that there are a lot of other variables that will affect Cal-COBRA coverage. For instance, Cal-COBRA will not be available for those who are eligible for Medicare, covered by another group's plan, failed to make premium payments, or their eligibility period is up. The individual also may not cherry pick. That is, if they had a combined medical and vision plan, they cannot pay for just the vision only. Also, Cal-COBRA requires some specific affirmative actions on the part of the employer and employee if the person intends to qualify for such benefits. Further Employer questions on the subject of Cal-COBRA should be discussed with legal counsel or either the California Department of Insurance, or the Department of Managed Health Care.

Premiums for Continuation Coverage

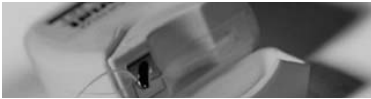
Federal COBRA permits a plan to charge an individual receiving COBRA coverage 102% of the cost of such coverage under the employer's plan. The plan may also charge up to 150% of the cost of coverage under the employer's plan for individuals who qualify for an extension of coverage from 18 to 29 months due to disability. Cal-COBRA allows the plan to charge 110% of the cost of coverage (150% for individuals whose coverage is extended due to disability). Therefore, if a federal COBRA beneficiary elects to extend his or her coverage under Cal-COBRA, the beneficiary could be charged more for such coverage. Also, based on the disparities in the rates permitted under federal and state law, the advantage for disabled individuals eligible for extended COBRA coverage under federal law is lost. It appears that if disabled individuals do not apply for a disability extension (an extra 11 months of coverage) to which disabled individuals are entitled under federal COBRA, the disabled individuals now can qualify for the entire additional 18 months under Cal-COBRA at a lower cost. Under COBRA,

only covered employees, spouses and Dependent children may be qualified beneficiaries. A domestic partner will not qualify as a spouse or Dependent child (even if state law were to recognize a same-sex domestic partner as an employee's spouse, that status would not apply for COBRA purposes). Thus, a covered employee's domestic partner, even if covered under the group health plan, will not be a qualified beneficiary and will have no independent COBRA election rights. Anyone covered under Senior COBRA continues the same basic health care benefits as were available under federal COBRA or Cal-COBRA. No restrictions based on pre-existing conditions are allowed. Specialized health care service plans, such as dental or vision plans, are not required to extend Senior COBRA.

*This section has been provided for information purposes only. It is neither meant to be legal advice, nor a substitute with discussing these important matters with your legal counsel.

UnitedHealthcare Dental Frequently Asked Questions by Plan Participants

- Q: Does my plan automatically entitle me to a free cleaning?
- A: Check your benefit literature to determine the level of benefits for your plan. Your assigned Provider Group is responsible for your overall dental health. The Provider Group will prescribe treatment based on your dental care needs. After your initial exam and X-rays, if a cleaning is diagnosed as appropriate treatment, he or she will let you know.
- Q: My dentist says I need scaling or root planing, but all I want is my cleaning. What is the difference?
- A: Periodontal or gum diseases can result in bone loss as well as loss of teeth. If you have some initial or more serious periodontal disease, a routine cleaning cannot reach the bacteria and calculus that forms under gum tissue and on the teeth. That's when your dentist will recommend deep scaling or root planing.
- Q: My dentist tells me that I need a crown on my molar. Does my plan pay for that?
- A: Check your plan or call Member Service at 1-877-816-3596 to request a pre-determination of coverage to see if your plan covers crowns. The cost can vary depending on the material used.
- Q: For a tooth extraction, can I get a fixed bridge replacement?
- A: Your dentist will decide if a fixed bridge replacement is appropriate.
- Q: Why did my dentist charge me more than the co-payment/coinsurance listed in my benefits book?
- A: Some procedures allow you to choose upgraded materials such as gold. Since you are financially responsible for the upgraded materials, this charge is added to your co-payment/coinsurance. All charges should be fully explained to you prior to receiving any procedures.



Q: What should I expect if I need dentures?

A: Be aware that dentures may require several office visits for adjustments. Be sure to ask your dentist what to expect when you are adjusting to dentures for the first time or replacing existing ones.

Q: What if I am unsure about my dentist's recommended treatment?

A: You are always welcome to call the Member Service department and request a second opinion.

Q: Will I be able to get an appointment right away with my selected Provider Group?

A: Your selected Provider Group should be able to see you for an examination within two to three weeks when you call for an appointment. Special appointments such as Saturdays or evenings may take longer.

Q: When I arrive for my appointment, how long will the wait be?

A: Your Provider Group schedules appointments to allow plenty of time for each patient's needs. However, sometimes emergencies occur or a previous patient takes longer than anticipated.

Q: Will I have to pay more if I visit a non-participating dentist?

A: Be sure to discuss fees up front with your dentist when he or she gives you a treatment plan. Out-of-pocket cost for a non-network dentist may be higher.

Q: May I get a second opinion?

A: Yes. Reimbursement will be subject to your plan's benefits.

Q: How do I file my claim?

A: You may submit a claim form directly to us, or your dentist can submit one for you. A claim form is provided to you in your plan materials or you may call Member Services at 1-877-816-3596 and request one from any of the friendly representatives available to help you.

Q: Where do I find a listing of participating dentists in my area?

A: Use your UnitedHealthcare Dental directory or call Member Services for assistance 1-877-816-3596. You may also search for dentists in your area on our Web site at www.myhcdental.com.

Q: What does "Usual, Customary and Reasonable" mean?

A: UCR (Usual, Customary and Reasonable) normally refers to not more than a dentist's usual charge, within the customary range of fees in the locality, and reasonable, based on the patient's dental circumstances. Normally, a health benefits plan will pay all or a portion of expenses incurred up to the UCR charge; expenses above the UCR charges must be paid by the patient in addition to the patient's coinsurance amounts.

Q: How can I know ahead of time what my out-of-pocket cost will be?

A: Ask your dentist for a predetermination of cost based on your plan's benefits. He or she can submit your proposed treatment plan to UnitedHealthcare Dental, and we'll send him or her an explanation of benefits. You will then be able to discuss your treatment and payment as a well-informed patient. The member can also utilize our on-line cost calculator via www.myuhcdental.com.

Dental Term Definitions

Diagnostic & Preventive Services contribute to improved oral health and therefore prevent or reduce the need for more costly restorative procedures. These services include examinations and X-rays (diagnostic procedures), as well as cleanings and fluoride treatments (preventive procedures)

Restorative Services cover basic restorations ("fillings"). These are either amalgam (metal based) or acrylic composite (plastic). Benefits are determined according to how many tooth surfaces are involved.

Oral Surgery may be required when a tooth can no longer be restored or saved. An extraction may be required if a tooth has extensive decay, a fractured root or other irreversible damage. The complexity of the procedure depends on the condition of the remaining tooth structure, its proximity to surrounding bone and other risk factors. Impacted teeth that require extraction may involve an oral surgeon.

Endodontics covers the complex procedure known as root canal therapy. The root canal involves drilling into the tooth's pulp or core, removing the dead or damaged nerve tissue, cleaning the walls of the canal and filling the canal with an inert rubber-like material.

Emergency means dental services required for the treatment of severe pain, swelling or bleeding, or the diagnosis and treatment of an unforeseen condition that may otherwise lead to disability, dysfunction or death.

Periodontics involves procedures for the treatment of the gums and other supporting structures of the teeth. Many dental conditions in adults are the result of poor oral hygiene and bone loss. Gum treatments - usually requiring the cleaning of bacterial calculus from underneath the gums - or surgical procedures may be included.

Fixed Prosthetics refers to crowns or bridges that may be used to restore broken down or decayed teeth when a filling will not suffice, or to replace missing teeth. After decay is removed, a crown or "cap" is placed over the prepared portion of the tooth. A restoration needed to replace a missing tooth is called a bridge. It consists of two abutment crowns and a pontic to replace the missing tooth. These fixed bridges are cemented permanently and are not removable.

Removable Prosthetics are a less expensive alternative to a fixed bridge. A removable partial denture replaces missing teeth. A removable partial denture may be fabricated to replace several missing teeth in a single arch (upper or lower). When all teeth in an arch are missing, a full denture is required. Both removable dentures and full dentures are permanent restorations, but they are not fixed and can be removed for routine oral hygiene.

Orthodontic Treatment or "braces" to straighten teeth is a benefit on many UnitedHealthcare Dental plans. Plan participants may be referred to a participating plan orthodontist who will accept the plan's co-payments/coinsurance for treatment, startup services, and retention fees. One treatment plan per lifetime is covered. The member co-payments/coinsurance covers 24 months of active treatment. Coverage is available for subscribers and eligible dependents.

Provider Nomination

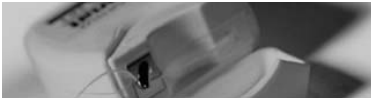
Members may nominate a provider via our Web site at www.myuhcdental.com.

Treatment Cost Calculator

The new myuhcdental.com Treatment Cost Calculator is a unique feature that offers more detailed dental benefit information online than any other major dental carrier. Enrollees can obtain cost and benefit information for each selected dental procedure, specific to their plan and selected provider. The easy-to-use calculator displays the enrollee's out-of-pocket expenses and identifies any applicable benefit limitations. Users can also compare costs for network and non-network treatments.

Network and non-network providers can also use the online Treatment Cost Calculator for a specified plan enrollee. Network providers can view network fee information and non-network providers will see only non-network information.

NOTE: The Treatment Cost Calculator is not available for members with DHMO coverage.



Your UnitedHealthcare Dental Key Contacts

UnitedHealthcare Dental®