DIESELUSAGROUP® - INCORPORATED -	United Healthcare Dental Plan Year Effective January 1, 2016	
PLAN NAME	**Incentive PPO - Primary Plan**	
DENTAL SERVICES	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
INDIVIDUAL ANNUAL DEDUCTIBLE	$50	$100
FAMILY ANNUAL DEDUCTIBLE	$150	$300
CALENDAR YEAR MAXIMUM (per person)	$1,000	$1,000
DIAGNOSTIC SERVICES	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Periodic Oral Evaluation	100%	100%
Radiographs	100%	100%
Lab and Other Diagnostic Tests	100%	100%
	Deductible does not apply to diagnostic services	
PREVENTIVE SERVICES	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Dental Prophylaxis (Cleaning)	100%	100%
Fluoride Treatment	100%	100%
Sealants	100%	100%
Space Maintainers	100%	100%
	Deductible does not apply to preventive services	
BASIC SERVICES	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Restorations (Amalgams or Composite)	80%	55%
Emergency Treatment/General Services	80%	55%
Simple Extractions	80%	55%
Oral Surgery (incl. surgical extractions)	80%	55%
Periodontics	80%	55%
Endodontics	80%	55%
	Deductible applies to basic services	
MAJOR SERVICES	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Inlays/Onlays/Crowns	50%	25%
Dentures and Removable Prosthetics	50%	25%
Fixed Partial Dentures (Bridges)	50%	25%
Implants	50%	25%
	Deductible applies to major services	
ORTHODONTIC SERVICES	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Orthodontia	50%	50%
Lifetime Maximum	$1,000	$1,000
Orthodontia Eligibility	Child Only (Up to Age 19)	
	Deductible does not apply to orthodontic services	
EMPLOYEE COST PER PAY PERIOD (26 PERIODS)		
Employee	**$5.59**	
Employee/Spouse	**$16.76**	
Employee/Child(ren)	**$22.37**	
Family	**$36.01**	

Note: This is a general summary of benefits. Please consult the certificate of coverage for complete details of the plan. If there is a discrepancy between this summary and the actual certificate will prevail.