UnitedHealthcare Dental®

You now have access to dental coverage

Taking good care of your teeth is an important part of maintaining your overall health. You now have access to a UnitedHealthcare Dental plan that offers you affordable dental care coverage when you need it.

We know your needs

We have the pleasure of serving millions of people just like you. As a retiree, we know you want quality, choice and coverage that works for you. We work hard to make our coverage comprehensive and easy to use. That's why we cover dental implants and offer significant savings on fillings, caps and other restorative services.

You have the advantage

With UnitedHealthcare Dental you have access to our nationwide network of dentists. And when you see a dentist in our network, you have the advantage of lower costs and never having to submit a claim form.

You have the flexibility

With the Dental Options PPO plan you have the flexibility of visiting a dentist outside of our network, if you prefer. Just keep in mind that you will have higher out-of-pocket costs and you will have to submit a claim form to be reimbursed. Just pay for the service up front and we'll reimburse you once you've met your deductible.

You have the resources

Use **myuhc.com** to find a dentist in your area, access your plan information, see your claim status, find general dental information and more. You also can call a dedicated Customer Care Center at **1-800-996-7563** any time and speak to a dental specialist for fast, knowledgeable service.

UnitedHealthcare Dental

- Visit any of the dentists in our national network.
- You don't have to submit a claim form when you visit a network dentist.
- You have the freedom to see a non-network dentist.
- You have dental implant coverage.
- Access Customer Care toll-free at **1-800-996-7563**.
- See your benefit details online at **myuhc.com**.

United Healthcare

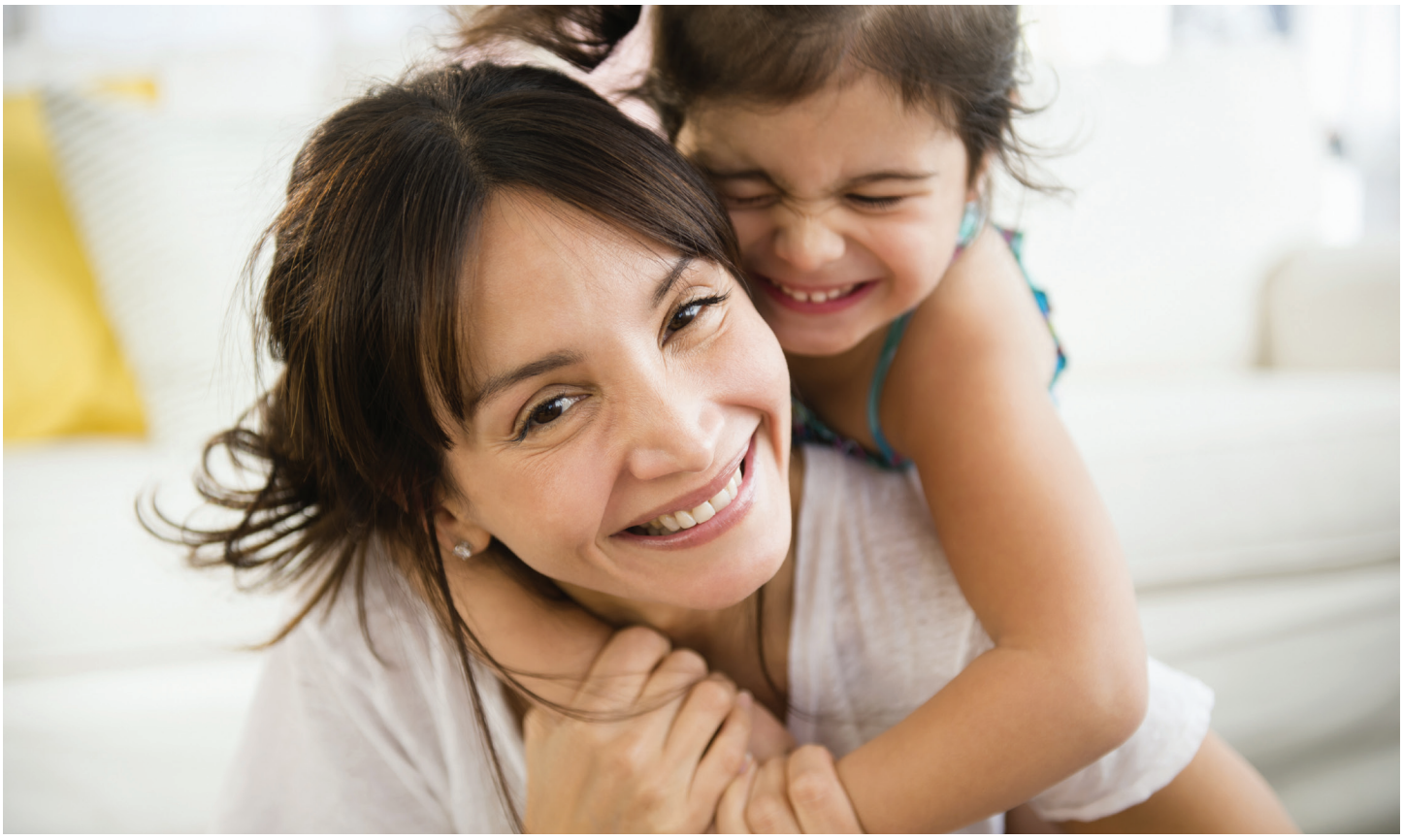
You have four plans and coverage levels to choose from:

	Plan # P4621/5160	Plan # P4622/5161	Plan # P5992/5734	Plan # P5993/5735
	Option 1	Option 2	Option 3	Option 4
Individual Annual Deductible (The sum of all network and non-network benefits will not exceed annual maximum.)	$100	$75	$100	$75
Annual Benefit Maximum	$1,000	$1,500	$1,000	$1,500
Out-of-Network Payment	Payments based on Reasonable & Customary fees	Payments based on Reasonable & Customary fees	Payments based on Reasonable & Customary fees	Payments based on Reasonable & Customary fees
Dental Plan Description	Low Plan with Dental Implants	High Plan with Dental Implants	Low Plan without Dental Implants	High Plan without Dental Implants
Your Individual Premium Per Member Per Month	**$45.23**	**$54.26**	**$41.61**	**$53.19**

If you see a non-network dentist, your out-of-pocket expenses may be higher. Many plans provide non-network plan payments based on Reasonable & Customary fees.

If your non-network dentist charges more than the amount allowable by your plan, you will pay the difference, in addition to your coinsurance amount.

See your dental plan summary sheets for details on covered services and the amounts of network and out-of-network coverage.



ConocoPhillips Retirees Individual member enrollment 2024

Instructions for completing enrollment form.

- **Check all appropriate boxes and print all information clearly.** (Please retain the brochure information until you receive your ID card.)
- **Subscriber: Fill out section completely.**
- **Dependents:** All dependents you wish to be covered should be listed in this section.
- **Method of Payment:** Please indicate your preferred method of payment, Monthly Auto Pay, Monthly Pay by Check or Credit Card. Should you choose the Monthly Auto Pay option, complete and sign the Pre-Authorized Payment Application on the adjacent page. UnitedHealthcare Dental will then automatically deduct the monthly premium from your checking account. Or, if you select the pay by check option, please include a check made payable to UnitedHealthcare Dental for the monthly premium.
- **Terms and Conditions**: Read the Terms and Conditions on the adjacent page and sign in the box at the "X" on the bottom of this sheet. This form must be signed for coverage to be effective. Your payment and completed enrollment form must be received by the 20th of the month for coverage to be effective the 1st of the following month.

Effective Date

Plan Option

Please select from one of the four plan options below by marking the appropriate check box.

☐ PPO Plan P4621/5160 (Option 1) ☐ PPO Plan P4622/5161 (Option 2) ☐ PPO Plan P5992/5734 (Option 3) ☐ PPO Plan P5593/5735 (Option 4)

Subscriber (you)

Please complete all sections. This form cannot be processed if information is incomplete.

Last Name	First Name	Middle Initial

Sex ☐M ☐F	Date of Birth / /	SSN / /	Home ( )

Mailing Address	City	State	ZIP Code	Work ( )

Email	Cell ( )

Dependents (your spouse and/or children)

Be sure to read the terms.

1

Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial

Sex ☐M ☐F	Date of Birth / /	SSN / /

2

Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial

Sex ☐M ☐F	Date of Birth / /	SSN / /

3

Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial

Sex ☐M ☐F	Date of Birth / /	SSN / /

4

Relationship (spouse, daughter, son)	Last Name	First Name	Middle Initial

Sex ☐M ☐F	Date of Birth / /	SSN / /

Payor (if not you)

This section must be completed by the individual who will be responsible for paying for the plan.

Last Name	First Name	Middle Initial	Email Address

Address	City	State	ZIP Code

Be sure to read the terms and conditions on the following page, and sign at the "X" by this symbol:

Mail To:
ATTN: M/S CA 120-0451
UnitedHealthcare Dental
P.O. Box 6020
Cypress, CA 90630-0020

Telephone:
1-800-996-7563
Fax: **1-844-608-0601**

Terms and Conditions

Please complete all sections. This form cannot be processed if information is incomplete.

I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical/dental malpractice (that is as to whether any dental services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and UnitedHealthcare Dental or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. However, in the event the amount in controversy in the dispute including any claims of damage is not greater than $5,000.00, such disputes are not subject to binding arbitration hereunder. Disputes in which more than $5,000.00 is in controversy will not be resolved by a lawsuit or resort to court process, except as applicable law may provide for judicial review of arbitration proceedings. By enrolling in UnitedHealthcare Dental, both member (including any heirs or assigns) and UnitedHealthcare Dental entities agree to waive the constitutional right to a jury trial and instead voluntarily agree to the use of binding arbitration as described in the Evidence of Coverage. Request for disenrollment or changes in coverage must be received in writing by the 20th of the month to be effective same month. You can fax, mail or email changes:

Fax: 1-844-608-0601

Email: sg13001@uhc.com

Mail: ATTN: M/S CA 120-0451
UnitedHealthcare Dental
P.O. Box 6020
Cypress, CA 90630-0020

Method of payment

Please complete all sections. This form cannot be processed if information is incomplete.

☐ **Monthly Auto Pay.**
Complete the attached Pre-Authorized Payment Application and include a voided check.

☐ **Monthly Pay by Check.**
Include a check payable to UnitedHealthcare Dental for your monthly premium.

☐ **Pay by Credit Card (over the Phone).**
Please circle one (one-time, recurring).

Please complete all sections. This form cannot be processed if information is incomplete.

X

Subscriber Signature (This form must be signed by the Subscriber for coverage to be effective.) Date

Pre-Authorized Payment Application

Complete this section only if you want your monthly premium automatically deducted from your checking account and provide a voided check.

Our Pre-Authorized Payment Plan
It's the forget-proof method of paying your premium — almost as easy as payroll deduction. Just authorize us to debit your personal checking account each month. We'll do the rest. There will be no more paperwork for you and no more checks to write. No worries about monthly late-payment charges. And you'll save on postage and envelopes. It's easy, reliable and automatic.

2024 Calendar for Auto Debit

Jan 25	Apr 24	Jul 25	Oct 25
Feb 23	May 26	Aug 25	Nov 24
Mar 25	Jun 24	Sep 24	Dec 25

The auto debit process is 7 calendar days prior to the last day of the month except when that day is Saturday; then it will be Sunday. Please have your funds available for withdrawal on this day.

☐ **Automatic Payment(s)**
I (we) hereby authorize UnitedHealthcare to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account. I agree this authorization will remain in effect until you actually receive written notification of its termination from me.

Type of account: ☐ Checking ☐ Savings

Nine-digit Routing Number

Account Number

Financial Institution's Name _____

Address _____

City, State, ZIP _____

This auto debit process is 7 calendar days prior to the last day of the month except when that day is Saturday; then it will be Sunday. Please have your funds available for withdrawal on this day.

X _____

Authorized Account Signature

Individual dental benefits that will make you smile!

Learn more

1-800-996-7563 | **fax: 1-844-608-0601** | **uhc.com** | sg13001@uhc.com
ATTN: M/S CA 120-0451, UnitedHealthcare Dental, P.O. Box 6020, Cypress, CA 90630-0020

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Mail: UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

Online: **UHC_Civil_Rights@uhc.com**

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free member phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services:

Online: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201

We provide free services to help you communicate with us such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說**中文 (Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)를 사용하시는 경우 언어 지원** 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русский (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, निःशुल्क उपलब्ध है। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka›anída›awo›ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę› t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

United Healthcare