Dental Primary Plans

4 Plans[1] for Individuals & Families with Optional Vision Benefits[2]

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Golden Rule Insurance Company is the underwriter of these plans.
This product is administered by Dental Benefit Providers, Inc.

Policy Forms GRI-DEN3-JR, -50(AK), -01 (AL), -02 (AZ), -03 (AR), -04 (CA), -05 (CO), -06 (CT), (DE), -08 (DC), -09 (FL), -10 (GA), -51 (HI), -12 (IL), -13 (IN), -14 (IA), -15 (KS), -16 (KY), -17 (LA), -18 (ME), -19 (MD), -21 (MI), -22 (MN), -23 (MS), -24 (MO), -26 (NE), -27 (NV), -28 (NH), -29 (NJ), -30 (NM), -32 (NC), -33 (ND), -35 (OK), -36 (OR), -37 (PA), -38 (RI), -39 (SC), -40 (SD), -41 (TN), -42 (TX), -43 (UT), -44 (VT), -45 (VA), -47 (WV), -48 (WI), and -49 (WY); GRI-DEN3-JR-PB, -11 (ID), -34 (OH), -46 (WA); GRI-DEN3-JR-PBM, -11 (ID), -34 (OH), -46 (WA)

[1] Primary Preferred and Primary Preferred Plus are the only plans available in CO and MN. Primary and Primary Plus are the only plans available in ME. Primary Plus and Primary Preferred Plus are the only plans available in AK, ND, NJ, NV, SD, VT & WY.

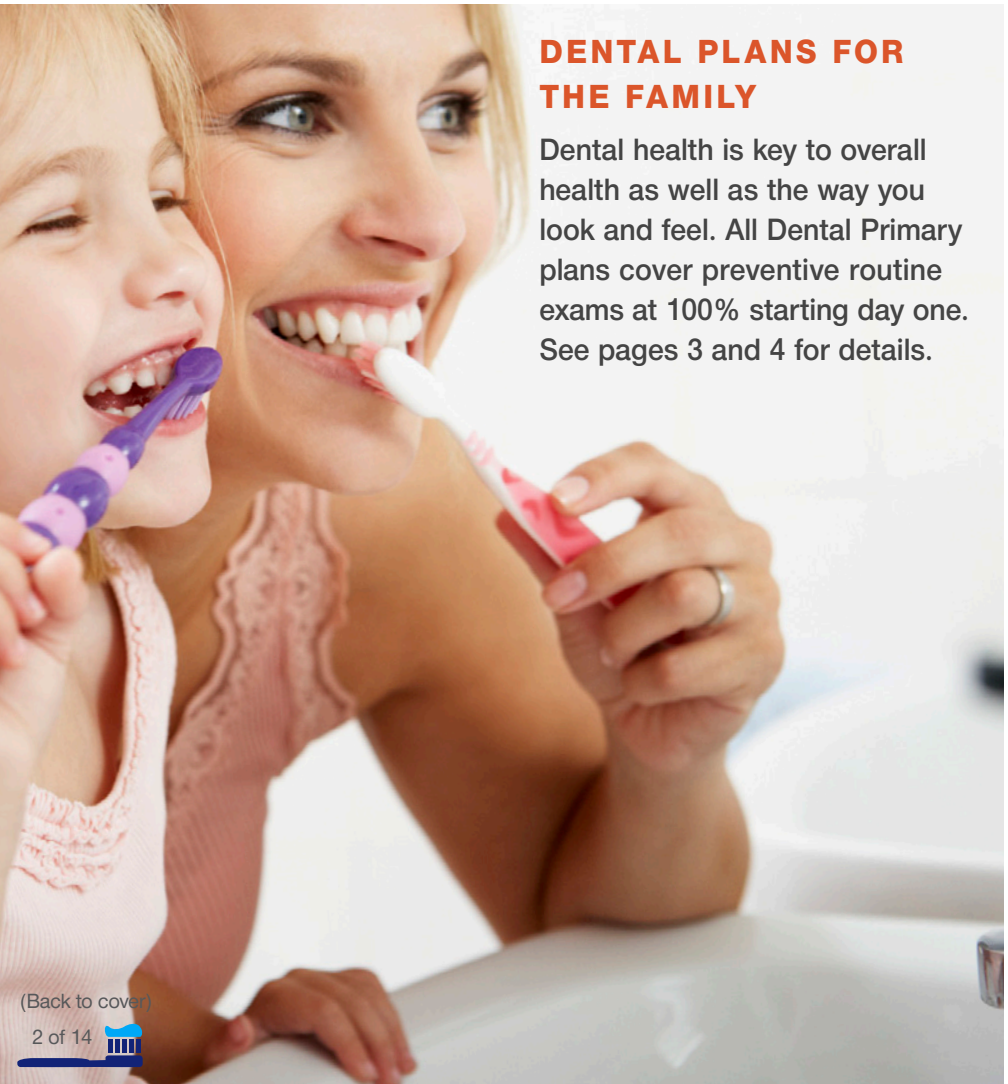
[2] The optional vision benefit is not available in MN, RI or WA.

UnitedHealthcare®
Golden Rule Insurance Company

The ratio of incurred claims to earned premiums (loss-ratio) for total accident and health for Golden Rule Insurance Company in all states in 2019 was 62.4%.
This is an outline only and is not intended to serve as a legal interpretation of benefits. Reasonable effort has been made to have this outline represent the intent of contract language. However, the contract language stands alone and the complete terms of the coverage will be determined by the policy. State-specific differences may apply.

What is your smile, your vision, and your ability to hear worth?

Life can be more enjoyable when you feel comfortable with your smile and can see and hear the world around you.

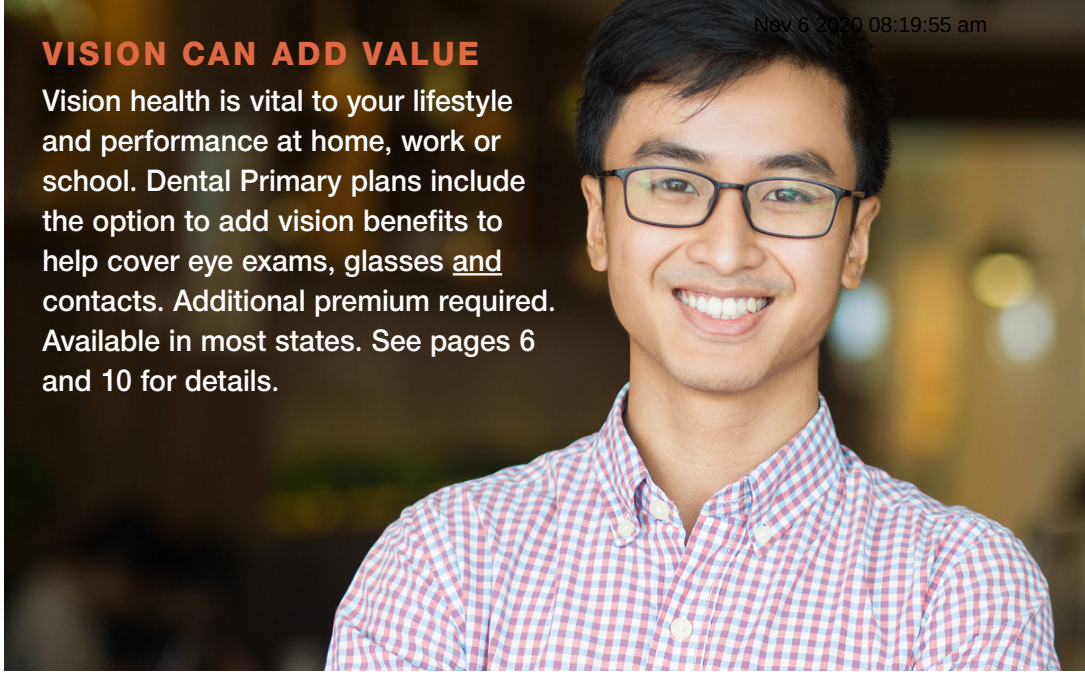


DENTAL PLANS FOR THE FAMILY

Dental health is key to overall health as well as the way you look and feel. All Dental Primary plans cover preventive routine exams at 100% starting day one. See pages 3 and 4 for details.

VISION CAN ADD VALUE

Vision health is vital to your lifestyle and performance at home, work or school. Dental Primary plans include the option to add vision benefits to help cover eye exams, glasses and contacts. Additional premium required. Available in most states. See pages 6 and 10 for details.



HEARING AID DISCOUNTS*

Hearing health is essential for social conversations, alertness and overall safety. UnitedHealthcare Hearing provides access to discounts on hearing exams and hearing aids. See page 5 for details.

*Hearing discounts are provided by UnitedHealthcare Hearing and are not insurance.

Find a dentist by clicking: **myuhc.com** > Under Links and Tools, select "Find a Dentist" > Select your state and the "National Options PPO 30" network

Primary[1,2]

Designed to offer immediate coverage and network discounts for preventive care and basic services. Plan availability varies by state.

Lower Premium

Preventive Care Services (includes routine cleaning & exams)	**Policy pays 100% day one**
	After Deductible:
Basic Services (includes simple fillings & extractions)	**Policy pays 50% day one** 65% after policy year one 80% after policy year two
Major Services (includes crowns, root canals, oral surgery, and bridges)	Not covered
Coverage Amount (per calendar year)	**$1,000 annual maximum**
Deductible (per calendar year, family max 3 deductibles)	**$50 per person** (basic services)
Most Valuable Feature	**Lowest premium** of Dental Primary plans

Primary Plus[2,3]

This plan pays more for non-network dentists on basic services than the other plans. There is also no waiting period for preventive care or basic services. Plan availability varies by state.

Use Any Dentist

Preventive Care Services (includes routine cleaning & exams)	**Policy pays 100% day one**
	After Deductible:
Basic Services (includes simple fillings & extractions)	**Policy pays 50% day one** 65% after policy year one 80% after policy year two
Major Services (includes crowns, root canals, oral surgery, and bridges)	Not covered
Coverage Amount (per calendar year)	**$1,000 annual maximum**
Deductible (per calendar year, family max 3 deductibles)	**$50 per person** (basic services)
Most Valuable Feature	**Network Flexibility** of higher non-network benefits

Comparing Non-Network vs. Network[4]

				Non-Network Primary[1,2]	Non-Network Primary Plus[3,2]	Network Both Plans
Simple Filling	Retail charge:	**$181.14**	You pay:	**$152.64**	**$90.57**	**$28.50**

[1] Pays non-network provider benefits based on the network negotiated rate. [2] Non-network dentists can bill a patient for any remaining amount up to the billed charge. [3] Pays non-network provider benefits based on the reasonable and customary charge. [4] Service pricing in ZIP Code 752– using policy year one and assuming the plan deductible has been met. Discounts vary by policy year, type of provider, geographic area, and type of service.

NO WAITING PERIODS **PREVENTIVE CARE**

ACCESS TO DISCOUNTS **ON HEARING AIDS**

OPTION TO ADD **VISION BENEFIT**

Find a dentist by clicking: **myuhc.com** > Under Links and Tools, select "Find a Dentist" > Select your state and the "National Options PPO 30" network

Primary Preferred[1,2]

Major services are covered, after a 6-month waiting period, using network dentists. Plan availability varies by state.

Includes Major Services

Preventive Care Services (includes routine cleaning & exams)	**Policy pays 100% day one**
	After Deductible:
Basic Services (includes simple fillings & extractions)	**Policy pays 35% day one[4]** 65% after policy year one 80% after policy year two
Major Services (includes crowns, root canals, oral surgery, and bridges)	**Policy pays 15% after[4]** 6-month waiting period 50% after policy year one 60% after policy year two
Coverage Amount (per calendar year)	**$1,000 annual maximum**
Deductible (per calendar year, family max 3 deductibles)	**$50 per person** (combined basic and major services)
Most Valuable Feature	**Major Services Coverage**

Primary Preferred Plus[2,3]

Enjoy the flexibility of using network or non-network dentists plus this plan covers major services after a 6-month waiting period.

Use Any Dentist + Major Services

Preventive Care Services (includes routine cleaning & exams)	**Policy pays 100% day one**
	After Deductible:
Basic Services (includes simple fillings & extractions)	**Policy pays 35% day one[4]** 65% after policy year one 80% after policy year two
Major Services (includes crowns, root canals, oral surgery, and bridges)	**Policy pays 15% after[4]** 6-month waiting period 50% after policy year one 60% after policy year two
Coverage Amount (per calendar year)	**$1,000 annual maximum**
Deductible (per calendar year, family max 3 deductibles per service type)	**$50 per person** (combined basic and major services)
Most Valuable Feature	**Network Flexibility with Major Services Coverage**

Comparing Non-Network vs. Network[5]

				Non-Network Preferred[1,2]	Non-Network Preferred Plus[3,2]	Network Both Plans
Simple Filling	Retail charges:	**$181.14**	You pay:	**$161.19**	**$117.74**	**$37.05**
Molar Root Canal		**$1,255.36**		**$1,170.01**	**$1,067.06**	**$483.65**

[1] Pays non-network provider benefits based on the network negotiated rate. [2] Non-network dentists can bill a patient for any remaining amount up to the billed charge. [3] Pays non-network provider benefits based on the reasonable and customary charge. [4] 50% in CT & IL. [5] Service pricing in ZIP Code 752– using policy year one and assuming the plan deductible has been met. Discounts vary by policy year, type of provider, geographic area, and type of service.

NO WAITING PERIODS
PREVENTIVE CARE

ACCESS TO DISCOUNTS
ON HEARING AIDS

OPTION TO ADD
VISION BENEFIT

ACCESS TO DISCOUNTS

ON HEARING AIDS

The cost of treatment can often be a prime concern for someone who has hearing loss. Did you know that studies have found that income can be significantly decreased by not wearing hearing aids? Hearing loss can pose a significant barrier to everything from productivity and overall career success to household earnings.[1] "Because hearing loss often occurs gradually, it can be difficult to recognize when you have it."[2]

Learn more about discounts on hearing exams and hearings aids through UnitedHealthcare Hearing.

UnitedHealthcare Hearing

KEY FEATURES

- **Over 5,000 hearing providers nationwide[3]**
- **Hearing exams and hearing aid evaluations**
- **Name-brand and private-labeled hearing aids**
- **Order hearing aids in person or through home delivery**

Learn more about UnitedHealthcare Hearing discounts: uhchearing.com

Hearing Discount Example

Jen notices she often has to ask her family members to repeat themselves to her, so she decides to get a hearing exam. Jen works with UnitedHealthcare Hearing to schedule the hearing exam. After being diagnosed with some hearing loss, UnitedHealthcare Hearing calls Jen to discuss the different hearing aid options available. She is able to find hearing aids for less than retail with UnitedHealthcare Hearing's help.

By calling toll free at 1-855-523-9355, TTY 711, UnitedHealthcare Hearing can guide you through the process, handling the audiologist referral so you don't have to see your primary care physician first.

[1] 5 Ways Better Hearing Can Help Your Career, audiologyinc.net, October 2017
[2] Regular Screenings are Important hearingofamerica.com, May 2017
[3] 2019 UnitedHealthcare internal data.

Limited discounts available. Administered by UnitedHealthcare Hearing.
The people and events depicted here are fictional and do not represent actual cases.

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OPTION TO ADD

VISION BENEFIT[1]

Using your benefits is easy! Once your plan is effective, review your benefit information. Find a network doctor who's right for you to get the most out of your eye care experience.[2] Mention that you have UnitedHealthcare vision powered by Spectera Eyecare Networks. **Coverage starts day one, no ID card needed, no claim forms to fill out.**

COVERED EXPENSES
WHAT YOU PAY

Eye Exam Once every 12 months	**Network**	$10 copay
	Non-network	Any charge over $50 allowance
Eyeglass Frames[3] Once every 12 months	**Network**	Any charge over $150 allowance
	Non-network	Any charge over $75 allowance
Eyeglass Lenses One pair every 12 months (of any type)[3]	**Network**	$10 copay
	Non-network	Any charge over: $40 allowance (Single Vision); $60 allowance (Bifocal); $80 allowance (Trifocal/Lenticular)
and Contacts:		
Contacts Once every 12 months	**Network**	Select Contact Lenses List: $0 Copay Non-Selection Contacts: Any charge over $150 allowance
	Non-network	Any charge over $105 allowance

Optional Vision Benefit Example

Jane has vision coverage with her family's dental plan. She is able to get a new pair of glasses every 12 months for her daughter who needs them more often as she grows. She can even get contacts in addition to glasses every year when her daughter wants to change up her look.

Our network includes private practices along with leading retail locations.

Popular retailers include:			Find additional retailers here.
20/20 Vision Center	**America's Best**	**Costco Optical**	**Eyeglass World**
National Vision	**Sam's Club**	**Visionworks**	**Walmart**

Additional premium required for adding the vision benefit. Not available in all areas. Details and limits to coverage are listed in the policy.

[1] Vision benefit not available in MN, RI, or WA.

[2] You may go outside the network, but are eligible for better discounts using network providers.

[3] See eyeglass frames and lens coverage details on page 10.

Administered by Spectera, Inc. Policy Form SA-S-1884-GRI

The people and events depicted here are fictional and do not represent actual cases.

Other Details
(all dental plans)

This is only a general outline of the basic policy provisions and exclusions. State-specific differences may apply. It is not an insurance contract, nor part of the insurance policy. You will find complete details in the policy.

This brochure may be used in the following states:

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Michigan
Mississippi
Missouri
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
West Virginia
Wisconsin
Wyoming

Basic Policy Details

State-specific differences may apply. All services are subject to annual maximums and may be subject to deductible and coinsurance.

All Plans: Preventive Services

- Routine exams and cleanings – limited to 2 per calendar year
- X-rays (bitewing) – limited to 1 series per calendar year
- X-rays (full mount panoramic) – limited to 1 per 36 months
- Eligible children's services (under the age of 16; in IL, under the age of 19):
  - Fluoride treatments – limited to 2 times per calendar year
  - Space maintainers – limited to once per 60 months plus adjustments within 6 months of installation.
  - Sealants – limited to once per first and second permanent molar every 36 months

All Plans: Basic Services

- Fillings – amalgam and composite (composite is limited to anterior tooth)
- Simple nonsurgical extractions
- General anesthesia – in conjunction with oral surgery or the removal of 7 or more teeth
- Local anesthesia

Preferred Plans Only: Major Services

(as limited in the policy)

- Root canals – limit 1 time per tooth, per lifetime
- Crowns – limit 1 per tooth, per 60 months
- Surgical extraction of erupted tooth or roots – limited to 1 time per tooth per lifetime
- Full dentures – limited to 1 per 60 months
- Bridges – limited to 1 time per 60 months

Calendar Year vs. Policy Year

A calendar year runs from January to December and starts over on January 1 of the following year. Each plan's annual maximum coverage amount and deductible apply during the calendar year.

A policy year is the anniversary of the plan's effective start date. The increasing coinsurance applies to the plan's policy year.

Change or Misstatement of Residence (Address)

You must notify us within 60 days of changing your residence. Your premium based on your new residence will begin on the first due date after the change. If you misstate your residence on the application or fail to notify us of a change of residence, we will apply the correct premium on the first due date you resided at that residence. If the change results in: lower premium, we will refund any excess; higher premium, you will owe us (misstatement not applicable in AL or VT).

Eligibility

At the time of application, primary insured must be 18-64 years of age. Spouse (as defined by state) may be of any age. Eligible children 0-25 years of age (drop off on 26th birthday) or as required by state. In HI, an eligible dependent includes a reciprocal beneficiary.

Misstatement of Age

If the covered person's age has been misstated on the covered person's application for coverage under the policy, any future premiums may be adjusted and past premiums may be refunded or owed to us, or benefits may be adjusted, based on the correct age. If a covered person's age has been misstated and we would not have issued coverage for that covered person, we will refund the premium paid minus any benefit amounts paid by us, and coverage would be void from the effective date.

Other Details
(all dental plans)

This is only a general outline of the basic policy provisions and exclusions. State-specific differences may apply. It is not an insurance contract, nor part of the insurance policy. You will find complete details in the policy.

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Delaware
District of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Michigan
Mississippi
Missouri
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
West Virginia
Wisconsin
Wyoming

Non-Network vs. Network

You may pay more using non-network providers. Non-network providers may bill you for any amount up to the billed charge after the plan has paid its portion.

Network providers have agreed to discounted pricing for covered expenses with no additional billing to you other than the copayment, coinsurance, and deductible amounts.

Premium

You will be given at least a 31-day notice (or longer if required by your state) of any change in your premium. We will make no change in your premium solely because of claims made by a covered person under the policy.

The covered persons type and level of benefits and place of residence on the premium due date are some of the factors that may be used in determining your premium rates.

Renewability and Termination

The policy is renewable until the earliest of the following:

- The primary insured's death. If the policy includes dependents, it may be continued after the primary insured's death:
  - By the spouse, if the spouse is a covered person
  - Otherwise, by the youngest child who is a covered person;
- Nonpayment of premiums when due;
- The date we receive a request from you to terminate the policy;
- The date we decline to renew all policies issued on this form with the same type and level of benefits in your state of residence; or
- The date there is fraud or a misrepresentation made by or with the knowledge of a covered person.

General Exclusions and Limitations

No benefits will be paid for any services not identified or included as covered expenses under the policy. You will be fully responsible for payment for any services which are not covered expenses.

No benefits are payable for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

- Incurred prior to the effective date, during the waiting period, or after the termination date of the policy.
- Exceeds the non-network provider reimbursement, the frequency limitations, or maximum benefits.
- Not rendered within the scope of the dentist's license.
- Payable under a medical policy issued by us, except in states that require this to be covered.
- Hospital or other facility charges and related anesthesia charges.
- Conscious sedation, analgesia, anxiolysis, and inhalation of nitrous oxide.
- Surgical extraction of wisdom teeth.
- Reconstructive surgery.
- Cosmetic dentistry.
- Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies; prescription and non-prescription drugs, that are not dispensed and utilized in the dental office during your visit; sterilization fees; treatment of halitosis and any related procedures; lab procedures.
- Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis.
- Acupuncture, acupressure, and other forms of alternative treatment.
- Telephone consultations or for failure to keep a scheduled appointment.

Other Details
(all dental plans)

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District of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
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Kansas
Kentucky
Louisiana
Maine
Maryland
Michigan
Mississippi
Missouri
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
West Virginia
Wisconsin
Wyoming

General Exclusions and Limitations, continued

No benefits are payable for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

- Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations).
- Intoxication, as defined by applicable state law in the state where the loss occurred, or under the influence of illegal narcotics or controlled substance, unless administered or prescribed by a doctor.
- Experimental or investigational treatment or complications therefrom. (does not apply in VA)
- Which arise out of, or in the course of your employment for wage or profit (CA, FL, NC – applies if paid by worker's compensation).
- Any act of war, participation in a riot, intentionally self-inflicted bodily harm, or commission or attempt to commit a felony.
- Provided free of charge without this insurance or by a government plan or program.
- Provided by a family member or by someone who ordinarily resides with a covered person. (Does not apply in TX. Does not apply in SD if household member is only provider in 50 mile radius. Someone who ordinarily resides with a covered person does not apply in VA.)
- Received outside of the United States, except for a dental emergency.
- Related to temporomandibular joint, upper and lower jaw bone surgery (does not apply in MN or NM), or orthognathic surgery (does not apply in MN).
- Teeth that can be restored by other means; periodontal splinting, to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis.
- Maxillofacial prosthetics and related services.
- Orthodontics or dental implants and any related procedure.
- To alter vertical dimension and/or restore or maintain occlusion, bite analysis, or congenital malformation.
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal; treatment of malignant neoplasms or congenital anomalies.
- Mouthguards, precision or semi-precision attachments, occlusal guards, bruxism appliances, duplicate dentures, harmful habit appliances, replacement of lost or stolen appliances, or sleep disorder appliances.
- Provided as a result of a prohibited referral (MD only).

The following exclusion applies only to the Primary and Primary Plus plans:

- Major services, which include all procedures or services related to endodontics, periodontics, major restorative services (crowns, inlays, onlays and veneers), prosthetics (bridges and dentures), and oral surgery.

The following Exclusions and Limitations apply to Primary Preferred and Primary Preferred Plus plans for Major Services:

- Initial placement of full or partial dentures or bridges and related services, to replace functional natural teeth that are congenitally missing or lost before insurance under the policy is in effect.
- Replacement of full or partial removable dentures, bridges, crowns, inlays, onlays, or veneers which can be repaired or restored to natural function.
- Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error.
- Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- Placement of fixed partial dentures solely to achieve periodontal stability.

Vision Details
(optional benefit)

This is only a general outline of the basic policy provisions and exclusions. State-specific differences may apply. It is not an insurance contract, nor part of the insurance policy. You will find complete details in the policy.

This brochure may be used in the following states:

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Michigan
Mississippi
Missouri
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
West Virginia
Wisconsin
Wyoming

How the Vision Program Works

Your out-of-pocket expenses – what you'll owe for vision services – will vary depending on the type of provider you use:

- **For Network Vision Providers:** After your copay, they agree to accept the plan payment as full reimbursement for covered expenses. Check our online list of providers. They are categorized in three ways:
  - Full service – are contracted to provide eye exams and prescription eyewear at discounted rates.
  - Exam Only – are contracted to provide exams ONLY at discounted rates.
  - Dispense Only – are contracted to dispense prescription eyewear ONLY at discounted rates.
- **For Non-Network Vision Providers:** You must pay non-network providers in full at time of service. Then you submit itemized copies of receipts and request reimbursement from the UnitedHealthcare Vision Claims department (administered by Spectera, Inc.). Your out-of-pocket costs may be higher with a non-network provider.

Please Note: This vision benefit program is designed to cover vision needs rather than cosmetic extras. If those are selected, the plan will pay the costs of the allowed lenses and you will be responsible for the additional cost of the cosmetic extras.

In New Jersey, if you make an assignment of benefits, the network provider is responsible for requesting payment from us by filing the standard New Jersey claim form.

Eyeglass Frames and Lenses

The eyeglass frames benefit includes their fitting and subsequent adjustments to maintain comfort and efficiency. Eyeglass lenses may include single vision, bifocal, and trifocal/lenticular lenses. Additional costs for other types of lenses, lens materials and lens option extras may apply.

Vision Benefit Exclusions and Limitations

No benefits are payable for the following vision expenses:

- Orthoptics or vision therapy training and any associated supplemental testing;
- Plano lenses (a lens with no prescription on it);
- Oversized lenses;
- Replacement of eyeglass lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination or any corrective eyewear, required by an employer as a condition of employment;
- Corrective vision treatment of an experimental or investigative nature;
- Corrective surgical procedures such as, but not limited to, Radial Keratotomy (RK) and Photorefractive Keratectomy (PRK);
- Eyewear except prescription eyewear;
- Charges that exceed the allowed amount;
- Services or treatments that are already excluded in the General Exclusions and Limitations section of the policy; and
- Optional lens extras not listed in your policy.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MEDICAL INFORMATION PRIVACY NOTICE (Effective January 1, 2019)

We (including our affiliates listed at the end of this notice) are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you in our next annual distribution, either a revised notice or information about the material change or how to obtain a revised notice. We will provide this information either by direct mail or electronically in accordance with applicable law. In all cases, we will post the revised notice on our websites, such as *www.uhone.com, www.myuhone.com, www.uhone4me.com, www.myallsavers.com, or www.myallsaversconnect.com.* We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our customers. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and Federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information. We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage and to process claims for health care services you receive including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse detection or compliance programs. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services.
- **To Plan Sponsors.** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with Federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

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- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** including disclosures required by state workers' compensation laws that govern job-related injury or illness.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets Federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to Federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by Federal law.
- **Additional Restrictions on Use and Disclosure.** Certain Federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information: Alcohol and Substance Abuse, Biometric Information, Child or Adult Abuse or Neglect, including Sexual Assault, Communicable Diseases, Genetic Information, HIV/AIDS, Mental Health, Minors' Information, Prescriptions, Reproductive Health, and Sexually Transmitted Diseases.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by Federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under Federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, call the phone number listed on your health plan ID card.

What Are Your Rights. The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a PO Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept verbal requests to receive confidential communications; however, we may also require you to confirm your request in writing. In addition, any request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of health information that we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have it sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend information** we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below.
  If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which Federal law does not require us to provide an accounting.

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- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. In addition, you may obtain a copy of this notice at our websites such as *www.uhone.com, www.myuhone.com, www.uhone4me.com, www.myallsavers.com, or www.myallsaversconnect.com.*
- **You have the right to be considered a protected person.** *(New Mexico only)* *A "protected person" is a victim of domestic abuse who also is either: (i) an applicant for insurance with us; (ii) a person who is or may be covered by our insurance; or (iii) someone who has a claim for benefits under our insurance.*

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, you may contact a UnitedHealthOne Customer Call Center Representative. For Golden Rule members call us at 800-657-8205 (TTY 711). For All Savers members, call us at 1-800-291-2634 (TTY 711).
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed below.
- **Submitting a Written Request.** Mail to us your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record at the following address:
- Privacy Office, 7440 Woodland Drive, Indianapolis, IN 46278-1719
- **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

Fair Credit Reporting Act Notice. In some cases, we may ask a consumer-reporting agency to compile a consumer report, including potentially an investigative consumer report, about you. If we request an investigative consumer report, we will notify you promptly with the name and address of the agency that will furnish the report. You may request in writing to be interviewed as part of the investigation. The agency may retain a copy of the report. The agency may disclose it to other persons as allowed by the Federal Fair Credit Reporting Act.

We may disclose information solely about our transactions or experiences with you to our affiliates.

MIB. In conjunction with our membership in MIB, Inc., formerly known as Medical Information Bureau (MIB), we or our reinsurers may make a report of your personal information to MIB. MIB is a not-for-profit organization of life and health insurance companies that operates an information exchange on behalf of its members.

If you submit an application or claim for benefits to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply such company with information regarding you that it has in its file.

If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. Contact MIB at: MIB, Inc., 50 Braintree Hill Park Ste. 400, Braintree, MA 02184-8734, 1-866-692-6901, *www.mib.com*.

FINANCIAL INFORMATION PRIVACY NOTICE (Effective January 1, 2019)

We (including our affiliates listed at the end of this notice) are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an insured or an applicant for coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing coverage to the individual.

Information We Collect. Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information. We do not disclose personal financial information about our insureds or former insureds to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

We restrict access to personal financial information about you to employees, affiliates and service providers who are involved in administering your health care coverage or providing services to you. We maintain physical, electronic and procedural safeguards that comply with Federal standards to guard your personal financial information.

Confidentiality and Security. We maintain physical, electronic and procedural safeguards, in accordance with applicable state and Federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice. If you have any questions about this notice, you may contact a UnitedHealthOne Customer Call Center Representative. For Golden Rule members call us at 1-800-657-8205 (TTY 711). For All Savers members, call us at 1-800-291-2634 (TTY 711).

The Notice of Privacy Practices, effective January 1, 2019, is provided on behalf of All Savers Insurance Company; All Savers Life Insurance Company of California; Golden Rule Insurance Company; Oxford Health Insurance, Inc.; UnitedHealthcare Insurance Company; and UnitedHealthcare Life Insurance Company. To obtain an authorization to release your personal information to another party, please go to the appropriate website listed in this Notice.

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Conditions Prior To Coverage (Applicable with or without the Conditional Receipt)

Subject to the limitations shown below, insurance will become effective if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by Golden Rule Insurance Company.
2. The first full premium, according to the mode of premium payment chosen, has been paid on or prior to the effective date, and any check is honored on first presentation for payment.
3. The policy is: (a) issued by Golden Rule Insurance Company exactly as applied for within 45 days from date of application; (b) delivered to the proposed insured; and (c) accepted by the proposed insured.

Failure to include all material medical information or correct information regarding the tobacco use of any applicant may cause the Company to deny a future claim and to void your coverage as though it has never been in force. After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded.

Keep this document. It has important information.

45585-G-1120

Golden Rule Insurance Company

Applies to policies issued in Wisconsin

Outline of Coverage for Policy Form GRI-DEN3-OC-JR-48

(Please retain this outline for your records.)

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for people with Medicare available from the Company.

Read Your Policy Carefully -- This outline sets forth a brief description of the important aspects of your policy. This is not the insurance contract. Only the actual policy will control. The policy sets forth in detail your and our rights and obligations. For this reason, it is important that you READ YOUR POLICY CAREFULLY!

In this outline, "you" or "your" will refer to the person for whom this outline has been prepared, and "we," "our," or "us" will refer to Golden Rule Insurance Company.

Dental Coverage -- Plans of this type are designed to provide the covered persons with coverage for dental care. The cost must be due to a covered dental service. Coverage is provided for preventive, basic, major services (If you plan includes major services) and orthodontic services (if your plan includes orthodontic services). Coverage is subject to any deductible amounts, coinsurance amounts, or other limitations that may be set forth in the policy.

Dental Benefits

DENTAL BENEFITS: Benefits are limited to the dental services described below, but only when each service is a covered expense:

PREVENTIVE SERVICES

A. Dental prophylaxis (cleanings), limited to 2-3 per calendar year depending on the plan.

B. Oral evaluations, limited to 2-3 per calendar year depending on the plan.

C. Problem focused oral evaluations.

D. Intraoral - Complete Series of radiograph images, limited to 1 per 36 months. Vertical bitewings not allowed in conjunction with a complete series.

E. Panoramic radiographs image, limited to 1 per 36 months.

F. Oral/Facial photographic images, limited to 1 per 36 months.

G. Intraoral bitewing radiograph, single image, limited to 4 per calendar year.

H. Intraoral bitewing radiographs, limited to 1 series per calendar year.

I. Intraoral periapical and intraoral occlusal radiographs image.

J. Extraoral radiographs, limited to 2 per calendar year.

K. Vertical bitewings 7-8 radiograph images, limited to 1 per 36 months.

L. Diagnostic casts, limited to 1 per 24 months.

M. Pulp vitality tests, limited to 1 charge per visit regardless of the number of teeth tested.

N. Adjunctive pre-diagnostic testing that aides in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedure, limited to 1 per calendar year.

O. Bacteriological and viral cultures.

P. Fluoride treatments, limited to covered persons under the age of 16 years, limited to 2 times per calendar year.

Q. Sealant, limited to covered persons under the age of 16 and once per first and second permanent molar every 36 months.

R. Preventive resin restorations in a moderate to high caries risk patient, limited to 1 per permanent tooth every 36 months.

S. Space Maintainers, limited to covered persons under the age of 16 years, once per 60 months. Benefit includes all adjustments within 6 months of installation.

T. Re-cement Space Maintainers, limited to 1 per 6 months after initial insertion.

BASIC SERVICES

A. Amalgam restorations, resin-based composite restorations, and gold foil restorations, (multiple restorations on one surface will be treated as a single filling).

B. Simple extractions.

C. Desensitizing medicament.

D. General anesthesia, in conjunction with oral surgery or the removal of 7 or more teeth.

E. Local anesthesia.

F. Therapeutic drug injection, limited to 1 per visit.

G. Palliative treatment, only if no other services other than exam and radiographs were done on the same tooth during the visit.

H. Consultations, when not performed with exams or professional visits.

I. For all covered expenses, the following dental services will be considered part of the entire dental service and not eligible for benefits as a separate service: cement bases; study models/ diagnostic casts; acid etch; and bonding agents.

MAJOR SERVICES (if included)

The following are included if your plan includes benefits for Major Services:

A. Apexification/recalcification/pulpal regeneration, limited to 1 time per tooth per lifetime.

B. Apicoectomy/periadicular surgery, limited to 1 time per tooth per lifetime.

C. Retrograde filling, limited to 1 per tooth per lifetime.

D. Hemisection, limited to 1 time per tooth per lifetime.

E. Root canal therapy, limited to 1 time per tooth per lifetime. Reimbursement not allowed for retreatment by original performing dentist in first 12 months.

F. Retreatment of previous root canal therapy. Reimbursement not allowed for retreatment by original performing dentist in first 12 months.

G. Root resection/amputation, limited to 1 time per tooth per lifetime.

H. Therapeutic pulpotomy, limited to 1 time per tooth per lifetime.

I. Pulpal therapy (resorable filling), limited to 1 time per tooth per lifetime. Covered for anterior or posterior teeth only.

J. Pulp caps (direct/indirect excluding final restoration), not covered if utilized solely as a liner or base underneath a restoration.

K. Pulpal debridement - primary and permanent teeth, limited to 1 per tooth per lifetime. Not covered on the same day as other endodontic services.

L. Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration, limited to 1 per tooth per lifetime.

M. Coping, limited to 1 per tooth per 60 months. Not covered if done at the same time as a crown on same tooth.

N. Crowns - retainers/abutments, limited to 1 per tooth per 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.

O. Crowns - restorations, limited to 1 per tooth per 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.

P. Temporary crowns - restorations, limited to 1 per tooth per 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.

Q. Stainless steel crowns, limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.

R. Protective restoration, 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.

S. Inlays/onlays - retainers/abutments, limited to 1 per tooth per 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.

T. Inlays/onlays - restorations, limited to 1 per tooth per 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.

U. Pontics, limited to 1 time per tooth per 60 months.

V. Retainer - cast metal for resin bonded fixed prosthesis, limited to 1 time per tooth per 60 months.

W. Pin retention, limited to 2 pins per tooth, not covered in addition to cast restoration.

X. Post and cores, covered only for teeth that have had a root canal therapy.

Y. Re-cement inlays/onlays, crowns, bridges, and post and core, limited to those performed more than 12 months after the initial insertion.

Z. Alveoloplasty, not covered for single tooth extractions.

AA. Biopsy, limited to 1 biopsy per site per visit.

BB. Frenectomy/frenuloplasty.

CC. Surgical incision, limited to 1 per site per visit.

DD. Removal of a benign cyst/lesions, limited to 1 per site per visit.

EE. Removal of torus, limited to 1 per site per visit.

FF. Surgical root removal, limited to 1 time per tooth per lifetime.

GG. Surgical extraction of erupted tooth or roots, limited to 1 time per tooth per lifetime.

HH. Surgical extraction of impacted teeth, limited to 1 time per tooth per lifetime.

II. Surgical access, surgical exposure, or immobilization of unerupted teeth, limited to 1 time per tooth per lifetime.

JJ. Primary closure of a sinus perforation, limited to 1 per tooth per lifetime.

KK. Placement of device to facilitate eruption of impacted tooth, limited to 1 time per tooth per lifetime.

LL. Vestibuloplasty, limited to 1 time per 60 months.

MM. Excision of hyperplastic tissue or pericoronal gingival, limited to 1 per site per 36 months.

NN. Appliance removal (not by dentist who placed appliance) includes removal of arch bar, limited to once per appliance per lifetime.

OO. Oroantral fistula closure, limited to 1 per site per visit.

PP. Transseptal fiberotomy/supra crestal fiberotomy, by report, limited to 1 time per tooth per lifetime.

QQ. Bone replacement graft for ridge preservation, per site, limited to 1 site per lifetime. Not covered in conjunction with other bone graft replacement procedures.

RR. Tooth reimplantation and/or transplantation services, limited to 1 per site per lifetime.

SS. Periodontal maintenance, limited to 2 per calendar year.

TT. Clinical crown lengthening, limited to 1 per quadrant or site per 36 months.

UU. Gingivectomy or gingivoplasty, limited to 1 per quadrant per 36 months.

VV. Anatomical crown exposure, limited to 1 per quadrant per 36 months.

WW. Gingival flap procedure, limited to 1 per quadrant per 36 months.

XX. Bone replacement graft, limited to 1 per quadrant per 36 months.

YY. Osseous surgery, limited to 1 per quadrant per 36 months.

ZZ. Biological materials to aid in soft and osseous tissue regeneration, limited to 1 per 36 months.

AAA. Guided tissue regeneration, limited to 1 per quadrant per 36 months.

BBB. Surgical revision procedure, limited to 1 per quadrant per 36 months.

CCC. Soft tissue surgery, limited to 1 per quadrant per 36 months.

DDD. Full mouth debridement, limited to 1 per 36 months.

EEE. Provisional splinting, not to be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.

FFF. Scaling or root planing, limited to 1 per 24 months.

GGG. Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report, limited to 3 sites per quadrant, or 12 sites total, for refractory pockets, or in conjunction with scaling or root planing, by report.

HHH. Fixed partial dentures (bridges), limited to 1 time per tooth per 60 months.

III. Full dentures, limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.

JJJ. Partial dentures, limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.

KKK. Tissue conditioning - maxillary or mandibular, limited to 1 time per 12 months.

LLL. Relining and rebasing dentures, limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.

MMM. Repairs or adjustments to full dentures, partial dentures, bridges or crowns, limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.

ORTHODONTIC SERVICES (if included)

The following are included if your plan includes benefits for Orthodontic Services:

We will provide benefits for orthodontic services, as shown in the policy Data Pages, for a covered eligible child under the age of 19.

Benefits for orthodontic services will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed or on the date a one-step orthodontic procedure is performed.

Benefits for orthodontic services end when the active orthodontic treatment ends or the orthodontic maximum is reached, whichever comes first.

Amount Payable

We will pay the applicable coinsurance percentage in excess of the applicable deductible amount and any copayment for the actual cost of services and supplies that qualify as covered expenses and are received while the covered person's coverage is in force under the policy.

A new deductible amount must be met each calendar year.

The maximum benefit per covered person, per calendar year is shown in the policy Data Pages.

Benefits for certain types of services will not be payable until after the waiting period has been satisfied.

What Is Not Covered

No benefits will be paid for any service or treatment for which charges incurred are not identified and included as covered expenses under this policy. You will be fully responsible for payment for any services for which charges incurred are not covered expenses under this policy.

This policy does not pay benefits for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

A. Not a covered expense or for which no charge is made.

B. Fees/surcharges imposed on the covered person by a provider but that are actually the responsibility of the provider to pay.

C. In excess of the frequency limitations or maximum benefits as shown in the policy Data Pages.

D. Covered expenses incurred during the waiting period.

E. Covered expenses which exceed the non-network provider reimbursement, as shown on the policy Data Pages.

F. Which no benefit is described in this policy or on the Data Page.

G. A dental service that is not rendered or that is not rendered within the scope of the dentist's license.

H. Major services, which includes all procedures or services related to endodontics, periodontics, major restorative services (crowns, inlays, onlays and veneers), dental implants, prosthetics (bridges and dentures, fixed or removable), and oral surgery, unless your plan includes benefits for Major Services.

I. Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service.

J. Telephone consultations or for failure to keep a scheduled appointment.

K. Any service incurred directly or indirectly as a result of the covered person being intoxicated, as defined by applicable state law in the state in which the loss occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a doctor or voluntary taking of any over the counter drug unless taken in accordance with the manufacturer's recommended dosage.

L. Experimental or investigational treatment or for complications there from, including expenses that might otherwise be covered if they were not incurred in conjunction with, as a result of, or while receiving experimental or investigational treatment.

M. Which arise out of, or in the course of, employment for wage or profit, if the covered person is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law.

N. Intentionally self-inflicted bodily harm (whether the covered person is sane or insane, any act of declared or undeclared war, a covered person taking part in a riot, or a covered person's commission or attempt to commit a felony, whether or not charged.

O. Provided by a government plan, program, hospital or other facility, unless by law a covered person must pay and it is otherwise a covered expense or which by law must be provided by an educational institution.

P. Provided without cost to a covered person in the absence of insurance covering the charge.

Q. Provided by an immediate family member or someone who ordinarily resides with a covered person.

R. Provided prior to the effective date or after the termination date of this policy.

S. Received outside of the United States, except for a dental emergency.

T. Related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

U. Teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis as determined by us.

V. Performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance such as internal/ external bleaching, veneers.)

W. Maxillofacial prosthetics and related services.

X. Reconstructive surgery, regardless of whether or not the surgery 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.

Y. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

Z. Changing vertical dimension; restoring occlusion; bite analysis, congenital malformation.

AA. Orthognathic surgery.

BB. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

CC. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal.

DD. Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.

EE. Replacement of full or partial removable dentures, bridges, crowns, inlays, onlays or veneers which can be repaired or restored to natural function.

FF. Mouthguards; precision or semi-precision attachments; duplicate dentures; harmful habit appliances; occlusal guard; replacement of lost or stolen appliances; treatment splints; bruxism appliance; sleep disorder appliance.

GG. Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies including but not limited to take-home fluoride; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures.

HH. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the covered person's dental visit.

II. Dental implants and any related procedures, including but not limited to crowns, bridges, and dentures, unless your plan includes benefits for implants.

JJ. Hospital or other facility charges and related anesthesia charges.

KK. Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis.

LL. Altering vertical dimension and/or restoring or maintaining occlusion. Such procedures include, but are not limited to, equilibrium, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

MM. Non-intravenous conscious sedation, analgesia, anxiolysis, inhalation of nitrous oxide and conscious sedation.

NN. Charges for dental services that are not documented in the dentist records, that are not directly associated with dental disease, or that are not performed in a dental setting.

OO. Orthodontic services, unless your plan includes benefits for orthodontic services.

PP. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

QQ. Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations).

RR. Two or more dental services are submitted and the dental services are considered part of the same dental service to one another, we will pay the most comprehensive dental service.

SS. Two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one dental service contradicts the need for the other dental service), we will pay for the dental service that represents the final treatment.

TT. Surgical extractions of wisdom teeth.

UU. Services for which benefits are payable under a medical policy issued by us.

VV. If you plan includes orthodontic services, orthodontic services do not include the installation of space maintainer, any treatment related to treatment of the temporomandibular joint, surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, repair of damages to orthodontic appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under this policy.

The following are applicable if your plan includes benefits for Major Services:

A. Initial placement of full or partial dentures or bridges and related services, to replace functional natural teeth that are congenitally missing or lost before insurance under this policy is in effect.

B. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

C. Replacement within 60 consecutive months of the last placement for full and partial dentures and replacement within 60 consecutive months of the last placement for crowns, bridges, inlays, onlays and veneers. This exclusion does not apply if the replacement is necessary because of extraction of a functioning natural tooth; or a present crown, bridge, or denture is temporary and a permanent crown, bridge or denture is installed within 12 months from the date the temporary service was installed.

D. Replacement of crowns, bridges, dentures and fixed or removable prosthetic appliances, implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), inserted prior to plan coverage unless the covered person has been insured 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, dental services associated with the addition will be covered when the service is a covered expense.

E. Replacement of complete dentures, fixed and removable partial dentures or crowns, implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), 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 the covered person's non-compliance, the covered person is liable for the cost of the replacement.

Definitions

"Grievance" means any dissatisfaction with us offering a health benefit plan or administration of a health benefit plan by us that is expressed in writing in any form to us by, or on behalf of, a covered person including, but not limited to, any of the following:

A. Provision of services.

B. Determination to reform or rescind a policy.

C. Claims practices.

Term of Coverage and Renewability

The policy term begins as of the effective date of the policy. You may keep the policy in force by paying us the required premium as it comes due. However, we may cancel the policy if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim.

Premium

From time to time, we may change the rate table used for this policy form. Each premium will be based on the rate table in effect on that premium's due date. The type and level of benefits and place of residence on the premium due date are some of the factors that could be used in determining your premium rates. At least 60-days written notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this policy or a change in a covered person's health.

California Nondiscrimination Notice and Access to Communication Services

Golden Rule Insurance Company does not exclude, deny covered health care benefits to or otherwise discriminate against any member on the ground of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability for participation in or receipt of the covered health care services under any of its health plans, whether carried out by Golden Rule Insurance Company directly or through a Network Medical Group or any other entity with which Golden Rule Insurance Company arranges to carry out covered health care services under any of its health plans.

Free services are available to help you communicate with us. Such as letters in other languages or in other formats like large print. Or you can ask for an interpreter at no charge. To ask for help, please call the toll-free number (800) 657-8205. TTY 711

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

Grievance Administrator
PO Box 31371
Salt Lake City UT 84131-0371
Fax: 801-478-5463
Phone: 800-657-8205
uhoappealsandgrievances@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 number listed on your health plan 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, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

California Language Assistance Notice

English
IMPORTANT LANGUAGE INFORMATION:
You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Spanish
INFORMACIÓN IMPORTANTE DEL LENGUAJE:
Puede tener derecho a los derechos y servicios a continuación. Puede obtener un intérprete o servicios de traducción sin cargo. La información por escrito también puede estar disponible en algunos idiomas sin cargo. Para obtener ayuda en su idioma, llame a su plan de salud al: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Chinese
重要語言信息：
您可能有權享受以下權利和服務。 您可以免費獲得口譯或翻譯服務。 書面信息也可能以某些語言免費提供。 如需獲得您的語言幫助，請致電您的健康計劃：Golden Rule Insurance Company 1-800-657-8205 / TTY：711.

Arabic
معلومات مهمة عن اللغة:
قد يحق لك الحصول على الحقوق والخدمات أدناه. يمكنك الحصول على مترجم أو خدمات ترجمة بدون مقابل. قد تكون المعلومات المكتوبة متاحة أيضاً في بعض اللغات دون مقابل. للحصول على المساعدة بلغتك ، يرجى الاتصال بخطة الرعاية الصحية الخاصة بك على العنوان التالي: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711

Armenian
ԿԱՐԵՎՈՐ ԼԵԶՎԻ ՏԵՂԵԿՈՒԹՅՈՒՆՆԵՐ.
Դուք կարող եք իրավասվել ստորեւ նշված իրավունքներին եւ ծառայություններին: Դուք կարող եք անվճար թարգմանիչ կամ թարգմանչական ծառայություններ ստանալ: Գրավոր տեղեկությունները կարող են մատչելի լինել նաեւ որոշ լեզուներով անվճար: Ձեր լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել ձեր առողջապահական ծրագիրը `Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Cambodian
ព័ត៌មានជាភាសាសំខាន់:
អ្នកអាចមានសិទ្ធិទទួលបានសិទ្ធិនិងសេវាកម្មដូចខាងក្រោម។
អ្នកអាចទទួលបានអ្នកបកប្រែឬអ្នកបកប្រែភាសាដោយឥតគិតថ្លៃ។
ព័ត៌មានដែលអាចសរសេរបានអាចមានជាភាសាមួយចំនួនដោយមិនគិតថ្លៃ។
ដើម្បីទទួលបានជំនួយជាភាសារបស់អ្នកសូមទូរស័ព្ទទៅផែនការសុខភាពរបស់អ្នកនៅ: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

45676-G-1118

Farsi

اطلاعات مهم در مورد زبان:

شما ممکن است به حقوق و خدمات زیر توجه داشته باشید. شما می توانید مترجم یا خدمات ترجمه را بدون هزینه دریافت کنید. اطلاعات نوشته شده ممکن است در بعضی از زبانها بدون پرداخت هزینه باشد. برای دریافت کمک به زبان خود، لطفا با برنامه بهداشتی خود تماس بگیرید:

Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Hindi

महत्वपूर्ण भाषा जानकारी:

आप नीचे अधिकार और सेवाओं के हकदार हो सकते हैं। आप बिना किसी शुल्क के एक दुभाषिया या अनुवाद सेवाएं प्राप्त कर सकते हैं। बिना किसी शुल्क के लिखित जानकारी कुछ भाषाओं में भी उपलब्ध हो सकती है। अपनी भाषा में सहायता प्राप्त करने के लिए, कृपया अपनी स्वास्थ्य योजना यहां कॉल करें: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Hmong

COV LUS LUS TSEEM CEEB:

Koj tuaj yeem tsim nyog tau cov cai thiab cov kev pab hauv qab no. Koj tuaj yeem tau txais neeg txhais lus los yog txhais lus pab dawb tsis them nyiaj. Cov ntaub ntawv sau kuj muaj nyob rau qee hom lus dawb xwb. Xav tau kev pabcuam ntawm koj hom lus, thov hu rau koj qhov kev npaj khomob ntawm: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Japanese

重要な言語情報：

あなたは以下の権利とサービスを受ける権利があります。 通訳や翻訳サービスを無料で受けることができます。 書かれた情報は、一部の言語で無償で入手できる場合もあります。 あなたの言語で助けを得るためには、あなたの健康計画に電話してください：Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Korean

중요한 **언어 정보 :**

귀하는 아래 권리와 서비스를받을 자격이 있습니다. 통역사 또는 번역 서비스를 무료로 받으실 수 있습니다. 서면 **정보**는 일부 **언어**로 무료로 제공 될 수도 있습니다. 귀하의 **언어**로 도움을 받으려면 다음의 건강 플랜에 전화하십시오. Golden Rule Insurance Company 1-800-657-8205 / TTY: 711..

45676-G-1118

Punjabi

ਮਹੱਤਵਪੂਰਨ ਭਾਸ਼ਾ ਜਾਣਕਾਰੀ:

ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ ਤੁਸੀਂ ਬਿਨਾ ਕਿਸੇ ਲਾਗਤ 'ਤੇ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ. ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਗੀਦਾਰਾਂ 'ਤੇ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ' ਤੇ ਵੀ ਉਪਲਬਧ ਹੋ ਸਕਦੀ ਹੈ. ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711

Russian

ВАЖНАЯ ИНФОРМАЦИЯ ЯЗЫКА:

Вы можете иметь право на права и услуги, указанные ниже. Вы можете бесплатно получить переводчика или услуги переводчика. Письменная информация также может быть доступна на некоторых языках бесплатно. Чтобы получить помощь на своем языке, позвоните в свой план медицинского обслуживания по адресу: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711

Tagalog

IMPORMASYONG IMPORMASYON SA LANGUAGE:

Maaaring may karapatan ka sa mga karapatan at serbisyo sa ibaba. Maaari kang makakuha ng isang interpreter o mga serbisyo ng pagsasalin nang walang bayad. Ang nakasulat na impormasyon ay maaari ding makuha sa ilang mga wika nang walang bayad. Upang makakuha ng tulong sa iyong wika, mangyaring tawagan ang iyong planong pangkalusugan sa: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Thai

ข้อมูลภาษาสำคัญ:

คุณอาจได้รับสิทธิ์และบริการด้านล่าง คุณสามารถขอรับบริการล่ามหรือแปลภาษาโดยไม่มีค่าใช้จ่าย ข้อมูลที่เป็นลายลักษณ์อักษรอาจมีให้บริการในบางภาษาโดยไม่มีค่าใช้จ่าย หากต้องการความช่วยเหลือในภาษาของคุณโปรดติดต่อแผนประกันสุขภาพของคุณได้ที่: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711

Vietnamese

THÔNG TIN NGÔN NGỮ QUAN TRỌNG:

Bạn có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể nhận dịch vụ phiên dịch hoặc dịch thuật miễn phí. Thông tin bằng văn bản cũng có thể có sẵn bằng một số ngôn ngữ miễn phí. Để nhận trợ giúp bằng ngôn ngữ của bạn, vui lòng gọi cho chương trình sức khỏe của bạn tại: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711