Dental Gen Plans

4 Plans[1] For Individuals 64+

Hearing Benefit[2] included with Option to add Vision Benefits[3]

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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-SR, -50 (AK), -01 (AL), -02 (AZ), -03 (AR), -04 (CA), -05 (CO), -06 (CT), -08 (DC), (DE), -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-SR-PBM, -11 (ID), -34 (OH), -46 (WA); GRI-DEN3-SR-PBM-I-46 (WA)

[1] Dental Gen Plus is the only plan available in AK, NJ, NV & WY.
[2] The hearing benefit is not available in WA.
[3] The optional vision benefit is not available in MN, RI or WA.

UnitedHealthcare®
Golden Rule Insurance Company

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.

45587C1WI-G-0821 (includes: 45587-G-0821 and 45630-G-1018)

Helping to Enhance Your Quality of Life

Your overall health and well-being rely greatly on your dental, hearing and vision care. When you smile more, and can hear and see better, life is naturally more enjoyable. Our Dental Gen plans can help you budget for dental expenses.

PREVENTIVE - BASIC - MAJOR

NO WAITING PERIODS[1]

Our Dental Gen plans offer you coverage without waiting periods so you can start using them right away! This means you have immediate coverage for routine services like exams and cleanings and major repairs like crowns and root canals.

INCLUDED COVERAGE

HEARING AIDS/EXAMS[2]

Hearing loss is an invisible problem that can affect your social life, safety and overall well-being. Our Dental Gen plans include benefits from UnitedHealthcare Hearing. UnitedHealthcare Hearing has straight-forward benefits for annual hearing exams and hearing aids.

OPTION TO ADD

VISION BENEFIT[3]

Vision health and routine eye exams have been linked to the early detection of some medical conditions. Our Dental Gen plans offer optional coverage for your annual vision exams, plus coverage for glasses or contacts. The vision network includes private practice and leading retail providers.

96% of US adults
aged 65+ have had a cavity.
— *cdc.gov* Center for Disease Control, May 2018

NETWORK SAVINGS

Gain access to a nationwide network of over 100,000 dental providers[4] and receive network discounts without the hassle of negotiations. Proper dental care can help keep issues like gum disease and tooth decay at bay — saving you money on future dental bills.

[1] In IL & CT, a 6-month waiting period applies on Major Services.

[2] Hearing benefit not available in WA.

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

[4] *uhc.com*
Ancillary Specialty Benefits Dental 2018

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

Gen Saver[1,2]

Designed to offer immediate coverage[4] for preventive, basic, and major services along with a hearing benefit at our lowest premium. Plan availability varies by state.

Our Lowest Premium

Preventive Care Services (includes routine cleaning & exams)	**Policy pays 60% day one** 70% after policy year one 80% after policy year two
	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)	**Policy pays 10% day one[4]** 40% after policy year one[4] 50% after policy year two
Coverage Amount (per calendar year)	**$1,000 annual maximum**
Deductible (per calendar year, family max 3 deductibles per service type)	**$100 per person** (combined basic and major services)
Most Valuable Feature	**Our Lowest Premium** of Dental Gen plans

Gen Plus[3,2]

This plan pays more for non-network dentists than the other plans. There is also no waiting period for preventive, basic or major services.[4]

Use Any Dentist

Preventive Care Services (includes routine cleaning & exams)	**Policy pays 60% day one** 70% after policy year one 80% after policy year two
	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)	**Policy pays 10% day one[4]** 40% after policy year one[4] 50% after policy year two
Coverage Amount (per calendar year)	**$1,000 annual maximum**
Deductible (per calendar year, family max 3 deductibles per service type)	**$100 per person** (combined basic and major services)
Most Valuable Feature	**Network Flexibility** of higher non-network benefits

Comparing Non-Network vs. Network[5]

				Non-Network Gen Saver[1,2]	Non-Network Gen Plus[3,2]	Network Both Plans
Routine Cleaning	Retail charges:	**$95.47**	You pay:	**$66.67**	**$38.19**	**$19.20**
Simple Filling		**$181.14**		**$152.64**	**$90.57**	**$28.50**
Molar Root Canal		**$1,255.36**		**$1,198.46**	**$1,129.83**	**$512.10**

[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] In CT & IL, after a 6-month waiting period, Major Services pays 50% and remains 50% after year one. [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.

PREVENTIVE - BASIC - MAJOR
NO WAITING PERIODS[4]

INCLUDED COVERAGE
HEARING AIDS/EXAMS

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

Gen Basic[1]

Start using your plan right away with immediate coverage for preventive services (100%) and basic services (50%). Another benefit is the higher annual max of $1,500. Plan availability varies by state.

100% Preventive Coverage

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)	**Policy pays 10% day one[2]** 40% after policy year one[2] 50% after policy year two
Coverage Amount (per calendar year)	**$1,500 annual maximum**
Deductible (per calendar year, family max 3 deductibles per service type)	**$100 per person** (combined basic and major services)
Most Valuable Feature	**Policy pays 100%** for Preventive Care Services & Higher Annual Max

Gen Deluxe[1]

With our highest annual maximum of $2,000, a lower combined deductible, plus coverage for dental implants under major services, this is our most comprehensive plan. Plan availability varies by state.

Covered Dental Implants

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 dental implants, crowns, root canals, oral surgery, and bridges)	**Policy pays 10% day one[2]** 40% after policy year one[2] 50% after policy year two
Coverage Amount (per calendar year)	**$2,000 annual maximum**
Deductible (per calendar year, family max 3 deductibles per service type)	**$50 per person** (combined basic and major services)
Most Valuable Feature	**Dental Implant Coverage** & Highest Annual Max

Comparing Non-Network vs. Network[3]

				Non-Network[1]	Network
Routine Cleaning		**$95.47**		**$47.47**	**$0**
Simple Filling	Retail charges:	**$181.14**	You pay:	**$35.58**	**$28.50**
Molar Root Canal		**$1,255.36**		**$1,198.46**	**$512.10**

[1] Pays non-network provider benefits based on the network negotiated rate. Non-network dentists can bill a patient for any remaining amount up to the billed charge. [2] In CT & IL, after a 6-month waiting period, Major Services pays 50% and remains 50% after year one. [3] Service pricing in ZIP Code 752– using policy year one and assuming the plan deductible has been met. Discounts vary by policy, type of provider, geographic area, and type of service.

PREVENTIVE - BASIC - MAJOR
NO WAITING PERIODS[2]

INCLUDED COVERAGE
HEARING AIDS/EXAMS

OPTION TO ADD
VISION BENEFIT

INCLUDED COVERAGE

HEARING AIDS/EXAMS[1]

The cost of treatment can often be a prime concern when someone has hearing loss. UnitedHealthcare Hearing can guide you through the process.

UnitedHealthcare Hearing KEY FEATURES

- **Over 5,000 hearing providers nationwide[2]**
- **Hearing exams and hearing aid evaluations**
- **Name-brand and private-labeled hearing aids**
- **Order hearing aids in person or through home delivery**

FIXED BENEFITS WHAT POLICY PAYS

Hearing Exam Once every 12 months	**$75 for an exam day one**
Hearing Aids Increasing benefit each year not utilized	**$100 day one** **$300 after policy year one** **$500 after policy year two** **$750 after policy year three**

Limited benefits available. This rider provides benefits in a stated amount regardless of the actual expenses incurred. Administered by UnitedHealthcare Hearing.

Learn more about UnitedHealthcare Hearing discounts: uhchearing.com

Hearing Benefit Example

Kathy has trouble hearing her friends while adventuring outside. After getting her annual hearing exam, she discovers she needs hearing aids. Having had her plan for 3 years, she receives $750 toward the cost of hearing aids in addition to repricing for using an UnitedHealthcare Hearing network provider. Her hearing benefit starts over at $100 the next year.[3]

Each year, your policy provides a benefit for an annual hearing exam.[2] You also have a hearing aid benefit available day one! The hearing aid benefit increases each year the benefit is not used, reaching a $750 maximum benefit.

By calling toll free at 1-855-523-9355, TTY 711, UnitedHealthcare Hearing coordinates the referral to see an audiologist 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] 2019 UnitedHealthcare internal data.
[3] Regular Screenings are Important hearingofamerica.com, May 2017

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

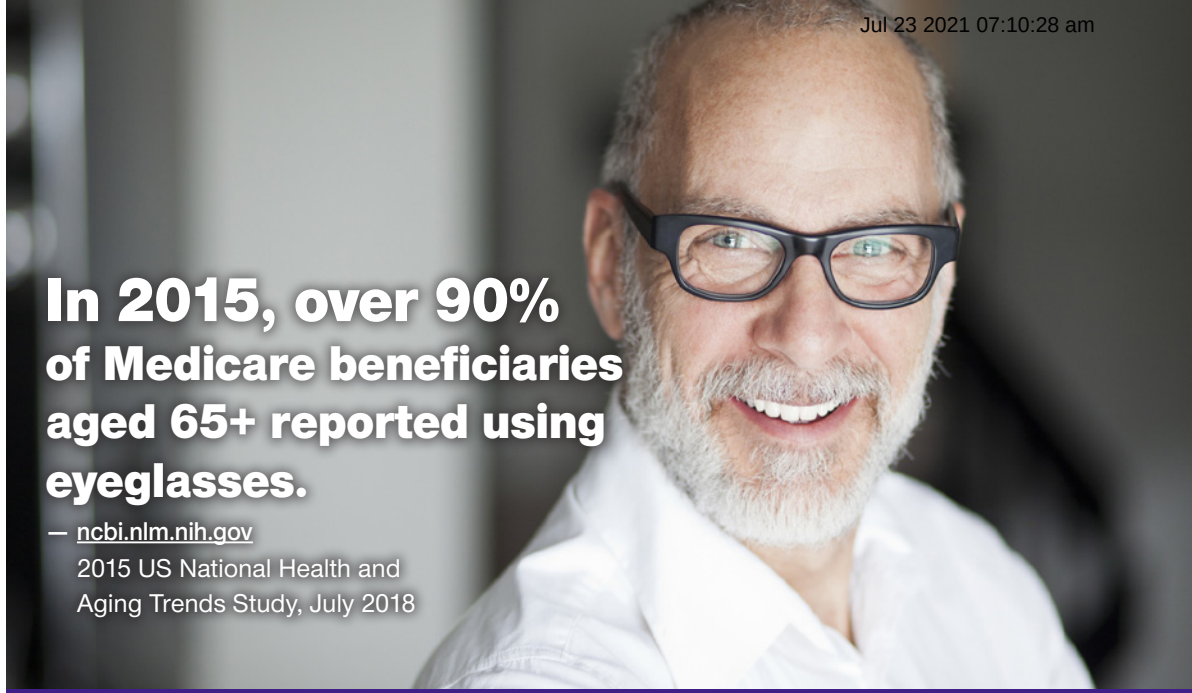
OPTION TO ADD

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
plus, either Glasses *or* Contacts:[3]		
Eyeglass Frames[4] 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)[4]	**Network**	$10 copay
	Non-network	Any charge over: $40 allowance (Single Vision); $60 allowance (Bifocal); $80 allowance (Trifocal/Lenticular)
Contacts Once every 12 months	**Network**	Select Contact Lenses List[5]: $0 Copay Non-Selection Contacts: Any charge over $150 allowance
	Non-network	Any charge over $105 allowance



Optional Vision Benefit Example

Tom sees a lot of value in his vision plan. Every 12 months, he is able to get $150 toward a new pair of frames and pay only a $10 copay for his lenses using the vision network. Next year, he can switch to getting contacts for no copay using the select contact list though the vision network.

The 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] Select either eyeglasses (lenses and/or frames) or contacts, not both.
[4] See eyeglass frames and lens coverage details on page 11.
[5] If you choose disposable contacts, up to 6 boxes are included when obtained from an in-network provider.

Administered by Spectera, Inc. Policy Form SA-S-1882-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
Minnesota
Mississippi
Missouri
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming

Basic Policy Details

State-specific differences may apply. (For CA, see 45587iCA-G after the brochure for state-specific details.) All services are subject to annual maximums and may be subject to deductible and coinsurance.

All Plans: Preventive Services

- Oral evaluations – limited to 2 per calendar year.
- Routine cleanings – limited to 2 per calendar year.
- X-rays (bitewing) – limited to 1 series per calendar year.
- X-rays (full mouth panoramic) – limited to 1 per 36 months.

All Plans: Basic Services

- Fillings – amalgam and composite (composite is limited to anterior tooth).
- Simple nonsurgical extractions – limited to 1 per tooth, per lifetime.
- General anesthesia – in conjunction with oral surgery or the removal of 7 or more teeth.
- Local anesthesia.
- Palliative treatment – only if no other services other than exam and radiographs were done on the same tooth during the visit.

All Plans: Major Services (as limited in the policy)

- Root canals – limit 1 time per tooth, per lifetime.
- Periodontal maintenance – limited to 2 per calendar year.
- 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 tooth, per 60 months.
- Repairs to crowns, dentures and bridges.
- Inlays/onlays – limit 1 per tooth, per 60 months.

Gen Deluxe Plans only: Implants

Implants are covered under Major Services and subject to the annual maximum – 1 time per tooth 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 time of application, the primary insured must be age 64 or older, while a spouse (as defined by state) of any age is eligible. Eligible children must be 0-25 years of age (drop off on 26th birthday) or as required by state. In HI, an eligible dependent includes a reciprocal beneficiary.

Other Details
(all dental plans)

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Hawaii
Idaho
Illinois
Indiana
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Kansas
Kentucky
Louisiana
Maine
Maryland
Michigan
Minnesota
Mississippi
Missouri
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming

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.

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.

Reimbursement
If dental services are caused by the acts or omissions of a third party we have the right to be reimbursed to the extent of benefits we paid for dental services (in MD, we will, to the extent of payment, be subrogated to all the rights of recovery), as outlined in the policy.

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.
- Which exceeds the non-network provider reimbursement.
- For a dental service that is not rendered or that is not rendered within the scope of the dentist's license.
- For dental services, including braces for any medical or dental condition, surgery and treatment for oral surgery, except as expressly provided for in the policy.
- Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service.
- Any dental services for which benefits are Payable under a medical policy issued by us.
- Charges for dental services that are not documented in the dentist records, not directly associated with dental disease, or not performed in a dental setting.
- Hospital or other facility charges and related anesthesia charges, analgesia, or conscious sedation.

Other Details
(all dental plans)

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Maine
Maryland
Michigan
Minnesota
Mississippi
Missouri
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
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:

- Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies, including but not limited to, take-home fluoride; prescription and non-prescription drugs, unless they are dispensed and utilized in the dental office during a covered person's dental visit; sterilization fees; diagnostic casts; 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.
- 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).
- Any dental services which result from 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 for complications there from. (does not apply in VA)
- Any dental service which results from or in the course of your employment for wage or profit (CA, FL, NC – applies if paid by worker's compensation).
- Any dental service which results from any act of war, participation in a riot, intentionally self-inflicted bodily harm, or commission or attempt to commit a felony.
- Maxillofacial prosthetics and related services; reconstructive surgery.
- Provided free of charge without this insurance or provided by a government plan, program, hospital or other facility unless by law you must pay.
- Any dental service 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.)
- Any dental service 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).
- Any dental service relating to 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.
- Orthodontia, braces, cosmetic dentistry, and any related procedure.
- Dental implants and any related procedure, unless included in your plan.
- Oral surgery, except as expressly provided for in the policy.
- 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).

Other Details
(all dental plans)

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Maryland
Michigan
Minnesota
Mississippi
Missouri
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming

General Exclusions and Limitations, continued

For Major Services, no benefits are payable for:

- 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 within 60 consecutive months of the last placement for full and partial dentures, crowns, bridges, inlays, onlays, and veneers.
- Replacement of crowns, bridges, dentures, fixed or removable prosthetic appliances, implants, implant crowns, implant prosthesis and implant supporting structure inserted prior to plan coverage unless the covered person has been insured under the plan for 12 continuous months.
- Replacement of complete dentures, fixed and removable partial dentures, crowns, implants, implant crowns, implant prosthesis and implant supporting structure 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 your or your dependents' non-compliance, you are liable for the cost of the replacement.
- 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.

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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

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

This rider includes a benefit to receive eyeglass frames and lenses OR contacts every 12 months. 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 (does not apply in AK);
- Corrective vision treatment of an experimental or investigative nature (does not apply in AK);
- Corrective surgical procedures such as, but not limited to, Radial Keratotomy (RK) and Photorefractive Keratectomy (PRK);
- Elective contact lenses if prescription eyeglass lenses and frames are received in any 12-month period;
- Prescription eyeglass lenses and frames if elective contact lenses are received in any 24-month period;
- 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.

Find a vision provider by clicking here: myUHCvision.com

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.

33638-X-201902 Products are either underwritten or administered by: All Savers Insurance Company, All Savers Life Insurance Company of California, Golden Rule Insurance Company, Oxford Health Insurance, Inc., UnitedHealthcare Insurance Company, and/or UnitedHealthcare Life Insurance Company.

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.

UnitedHealthcare®
Golden Rule
Insurance Company

45587-G-0821

Golden Rule Insurance Company

Applies to policies issued in Wisconsin

Outline of Coverage for Policy Form GRI-DEN3-OC-SR-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 services, basic services, and major services (if your plan includes major 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.

The following are included if your plan includes benefits for Implants:

A. Implant placement, limited to 1 time per tooth per 60 months.

B. Implant supported prosthetics, limited to 1 time per tooth per 60 months.

C. Implant maintenance procedures, includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis, limited to 1 per tooth per 60 months.

D. Repair implant supported prosthesis, limited to 1 time per tooth per 60 months.

E. Abutment supported crown (titanium) or retainer crown for FPD – titanium, limited to 1 time per tooth per 60 months.

F. Repair implant abutment by support, limited to 1 time per tooth per 60 months.

G. Radiographical/surgical implant index by report, limited to 1 time per tooth per 60 months.

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.

The total amount payable for each covered person 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 in the policy Data Pages.

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

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.

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.

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.