DentalWise Max

DentalWise® Max plans are dental and vision plans for individuals and families

Golden Rule Insurance Company is the underwriter of these policies. Benefits are administered as follows: Dental benefits - Dental Benefit Providers, Inc. and Vision benefits - Spectera, Inc.

Policy Forms: DEN-CH-GRI and other state variations

UnitedHealthcare®
Golden Rule Insurance Co.

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Dental and vision (DV) highlights

Coverage for your oral and eye health all together in one convenient plan designed with budget-friendly premiums in mind

Use dental benefits right away, no wait for most services

Our DentalWise Max plans offer you coverage without waiting periods for preventive, basic and most major services so you can start using them right away! This means you have immediate coverage for routine services like exams and cleanings, plus major repairs like crowns and root canals.

Eye exams and eyewear, no waiting period

Vision health and routine eye exams are not only important for seeing better, but also have been shown to help with early detection of certain medical conditions – helping you keep an eye on your overall health. Our DentalWise Max plans offer coverage for your annual vision exams with no waiting period, plus coverage for glasses and contacts. The vision network includes private practice and leading retail providers.

Access to UnitedHealthcare dental and vision networks

Access to dental and eye care professionals is an important part of using your plan and staying healthy. With DentalWise Max you have access to a large, nationwide network of dentists and optometrists, that have agreed to negotiated rates to help lower your cost.

Why dental and vision insurance?

Taking care of your health goes beyond regular medical checkups. Dental and vision health are just as important to your overall well-being. Having a supplemental plan like DentalWise Max can provide additional coverage to help protect your overall health and budget.

Helping to enhance your quality of life

Your overall health and well-being rely greatly on your dental and vision care. When you smile more and see better, life is naturally more enjoyable. Choosing a DentalWise Max plan can help enhance your quality of life and help you feel good about yourself.

Dental plan options

Our plan options allow you to select a plan that best balances your premium and out-of-pocket expenses, with your anticipated benefit use, giving you the freedom to choose what works best for you. And no matter which dental plan you choose, vision benefits are included (see pages 6-7 for details).

DentalWise Max plan availability All benefits are per insured person, per Policy Year[1] unless otherwise noted		**Plan 1000[2]**	**Plan 2000[2]**	**Plan 3000[2]**
Dental waiting period		None	None, except for Implants benefit only	None, except for Implants benefit only
Dental benefit deductible (per insured person, per Policy Year)	You pay:	$100	$100	$100
Dental Benefit Maximum (per insured person, per Policy Year)	We pay up to:	$1,000	$2,000	$3,000
Preventive services[3] (includes exams and x-rays)				
Includes 2 routine exams and cleanings per Policy Year	We pay:	100% (no deductible)	100% (no deductible)	100% (no deductible)
Basic services[3] (includes simple fillings)				
First Policy Year	We pay:	60% after deductible	60% after deductible	60% after deductible
Second Policy Year and after	We pay:	80% after deductible	80% after deductible	80% after deductible
Major services[3] (includes bridges, crowns, dentures, extractions, partials, root canals)				
First Policy Year	We pay:	15% after deductible	15% after deductible	15% after deductible
Second Policy Year and after	We pay:	50% after deductible	50% after deductible	50% after deductible
Implants (12 month waiting period) $1,500 Implant Maximum Lifetime Benefit[4]	We pay:	Not covered	50% after deductible	50% after deductible

State-specific differences may apply. (See State Variations for details.)

[1] Policy Year means each consecutive 12 month period beginning with the effective date. [2] For covered dental expenses, non-network provider benefits are determined by ZIP Code. They are either based on the network negotiated rate or are based on the reasonable and customary charge (reasonable and customary benefits are identifiable by the word "Plus" added to the plan name). [3] Limitations and exclusions may apply based on type of service. [4] The Implant Maximum Lifetime Benefit is separate from, and not subject to, the Dental Benefit Maximum. Implant benefit in Maine is limited to insured persons over age 18.

Dental benefit details

The following dental benefits are subject to Plan Provisions, Exclusions and Limitations, State Variations, the deductible, and any applicable coinsurance. This is only a general outline of the dental benefits. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy. Some state exceptions may apply (see State Variations).

Preventive services (all plans)

- Oral evaluations - 2 per Policy Year
- Routine cleanings - 2 per Policy Year
- Complete series of radiographic images - 1 per 36 months
- Bitewings, single film - 4 per Policy Year
- Vertical bitewings, 7 to 8 radiographic images - 1 per 36 months
- Panoramic radiographic images - 1 per 36 months
- For insured persons under the age of 16 years:
  - Fluoride treatments - 2 per Policy Year
  - Sealant - once per first and second permanent molar every 36 months

Basic services (all plans)

- Fillings - amalgam and resin-based composite (resin-based composite limited to anterior tooth) - multiple restorations on the same tooth will be treated as one filling
- Simple (non-surgical) extractions
- General anesthesia in conjunction with oral surgery or the removal of 7 or more teeth
- Local anesthesia
- Therapeutic drug injection, limited to 1 per visit

Major services (all plans except Basic)

- Bridges - 1 per tooth per 60 months
- Crowns - 1 per tooth per 60 months
- Full or partial dentures - 1 per 60 months
- Periodontal maintenance - 2 per Policy Year
- Root canals - 1 per tooth per lifetime
- Surgical extractions and oral surgery on erupted permanent teeth - 1 per tooth per lifetime

Implants (all plans except 1000 and 1000 Plus)

12 month waiting period applies. Implant related procedures are subject to Implant Lifetime Maximum Benefit of $1,500.

- Implant placement - 1 per tooth per 60 months
- Implant supported prosthetics - 1 per tooth per 60 months
- Implant maintenance procedures - 1 per tooth per 60 months

Dental benefit network

Dental benefits and how they work

Dental benefits are administered by Dental Benefit Providers, Inc. We will cover dental services subject to the terms, conditions, exclusions and limitations of the policy. All services are subject to Dental Benefit Maximum and applicable coinsurance. All services, except Preventive, are subject to deductible. State-specific differences may apply. (See State Variations for details.)

Network provider services

You can see any dentist you want, anywhere across the country. When you choose a dentist who is part of the large national network, National Options PPO 30, you can receive network discounts without the hassle of negotiations. Visit **yourdentalplan.com/dentistsearch** to find a provider and present the provider with your dental ID card. We will pay the provider the covered benefit, and the provider will bill you for the remainder.

There are no claim forms to fill out when obtaining services from a network provider.

Non-network provider services

The non-network provider may submit the claim to us directly. The provider can then bill you for any remaining amount due up to the billed charge. If a provider does not wish to submit the claim to us, you will need to pay in full at the time of service. You can then submit the claim for reimbursement by going to **myuhc.com** and completing the dental claim form.

Vision plan benefits

These vision benefits are included with your DentalWise Max plan, regardless of the dental plan you choose.

Vision benefits (per insured person once per Policy Year[1])			
Vision waiting period		None	
		Network[2]	**Non-network**
Routine eye exam		You pay $0 We pay 100%	We pay up to a $50 allowance
Standard lenses[3] and frames[4]	Single-vision lenses	You pay $10 copay We pay 100% after copay	We pay up to a $40 allowance
	Bifocal-lined lenses	You pay $10 copay We pay 100% after copay	We pay up to a $60 allowance
	Trifocal-lined lenses	You pay $10 copay We pay 100% after copay	We pay up to an $80 allowance
	Frames	We pay up to a $150 allowance	We pay up to a $75 allowance
Contact lenses Up to 12-month supply		You pay $10 copay We pay up to a $150 allowance	We pay up to a $105 allowance

What is an allowance?

An allowance is an amount payable, only once per Policy Year, up to the maximum amount, for a given service or material benefit. For example, if you purchase new frames from an **in-network provider** for $100, based on the benefits above, we would pay $100 because it is under the allowed amount. If your new frames were from a **non-network provider**, we would only pay $75 and you would be responsible for paying the remaining $25.

State-specific differences may apply. (See State Variations for details.)

[1] Policy Year means each consecutive 12 month period beginning with the effective date. [2] You may go outside the network, but you are eligible for discounts using network providers. Go to myuhcvision.com for a list of providers. [3] Standard lenses include single vision, bifocal-lined, and trifocal-lined/lenticular lenses, including standard scratch-resistant coating for eligible lenses as prescribed by a vision provider. [4] Standard frames include eyeglass frames, their fitting, and subsequent adjustments to maintain comfort and efficiency.

Vision benefit network

Vision benefits and how they work

Vision benefits are administered by Spectera, Inc. We will cover vision services subject to the terms, conditions, exclusions and limitations of the policy, Vision Benefit Rider SA-S-2097-CH-GRI, and other state variations. (See State Variations for details.)

Network provider services

These plans use the UnitedHealthcare Vision Network.* You will get the most value from your coverage when you see a provider in this large national network of eye doctors, optometrists and ophthalmologists, including both local doctors and well-known retail providers. Choose from network providers by visiting **myuhcvision.com**. Contact the provider, identify yourself as having UnitedHealthcare vision coverage, and provide your name and date of birth to get started.

No ID card is needed, and there are no claim forms to fill out when obtaining services from a network provider.

Non-network provider services

You will need to pay in full at the time of service. You may then submit the details to us for reimbursement of covered benefits. See Vision rider in the policy for details.

* Not all providers participate in all plans. Check with your provider before using your benefits.

Exclusions and Limitations

(insurance plans)

This is only a general outline of the exclusions. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy. Some state exceptions may apply (see State Variations).

Dental exclusions and limitations

General exclusions and limitations

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

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

- Fees/surcharges imposed on the insured person by a provider but that are actually the responsibility of the provider to pay
- Provided prior to the effective date or after the termination date of the policy
- In excess of the frequency limitations or maximum benefits as shown in the policy
- Covered expenses which exceed the non-network provider reimbursement, as shown in the policy
- A service that is not rendered or that is not rendered within the scope of the provider's license
- Telephone consultations or for failure to keep a scheduled appointment
- Any service incurred as a result of the insured 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
- Experimental or investigational treatment or for complications there from
- Which arise out of, or in the course of, employment for wage or profit, if the insured person is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law
- Intentionally self-inflicted bodily harm
- Any act of declared or undeclared war
- The insured person taking part in a riot
- The insured person's commission or attempt to commit a felony
- Provided by a government plan, program, hospital or other facility, unless by law an insured person must pay and it is otherwise a covered expense or which by law must be provided by an educational institution
- Provided without cost to an insured person in the absence of insurance covering the charge
- Provided by an immediate family member or someone who ordinarily resides with an insured person
- Received outside of the United States, except for a dental emergency
- Related to the temporomandibular joint (TMJ), upper and lower jaw bone surgery or orthognathic surgery
- 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
- Performed for cosmetic/aesthetic reasons
- 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
- 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
- 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
- Maxillofacial prosthetics and related services

Exclusions and Limitations continued
(insurance plans)

This is only a general outline of the exclusions. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy. Some state exceptions may apply (see State Variations).

Dental exclusions and limitations (continued)

- Hospital or other facility charges and related anesthesia charges
- 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
- 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
- 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
- Replacement of full or partial removable dentures, bridges, crowns, inlays, onlays or veneers which can be repaired or restored to natural function
- Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service
- Reconstructive surgery when the primary purpose is to improve physiological functioning of the involved part of the body
- Changing vertical dimension; restoring occlusion; bite analysis, 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 of hard or soft tissue, including excision
- Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis
- Altering vertical dimension and/or restoring or maintaining occlusion
- Non-intravenous conscious sedation, analgesia, anxiolysis, inhalation of nitrous oxide and conscious sedation
- Acupuncture; acupressure and other forms of alternative treatment
- 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)
- Surgical extractions of wisdom teeth

For Plan 1000 and 1000 Plus, the policy does not pay benefits for dental implants and any related procedures

For plans covering major services, the policy does not pay benefits for any service or treatment caused by, resulting from, for, which are, or relating to any of the following:

- Replacement within 60 consecutive months of the last placement for full and partial dentures, 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 dentures is temporary and a permanent crown, bridge or denture is installed within 12 months from the date the temporary service was installed.
- Replacement of complete dentures, fixed and removable partial dentures, or crowns, implants, implant crowns, implant prosthesis and implant supporting structures, 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 insured person's non-compliance, the insured person is 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 for the purpose of achieving periodontal stability

Exclusions and Limitations continued
(insurance plans)

This is only a general outline of the exclusions. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy. Some state exceptions may apply (see State Variations).

For plans covering major Services (continued)

- Initial placement of full or partial dentures or bridges and related services, to replace functional natural teeth that are: (a) congenitally missing; or (b) lost before insurance under the policy is in effect. However, benefits are available for covered expenses for initial placement of full or partial dentures or bridges to replace loss of functional natural teeth, including necessary adjustments during the first 6 months following the date of placement, only if: (a) the teeth were lost while the insured person was under the policy and the placement is within 12 months of the date of the loss of the teeth; or (b) the extraction took place while the insured person was both under age 16 and insured under the policy.
- Replacement of crowns, bridges, dentures and fixed or removable prosthetic appliances, implants, implant crowns, implant prosthesis and implant supporting structures, inserted prior to plan coverage unless the insured 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.

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

- Covered expenses incurred during the waiting period

Vision exclusions and limitations

Covered vision expenses will not include and no benefits are payable for any charges incurred for the following:

- Services or treatments that are already excluded in the general exclusions and limitations
- That is part of a covered expense that is subject to a copayment or is your responsibility
- Orthoptics or vision therapy training and any associated supplemental testing
- Non-prescription items (e.g. plano lenses).
- Oversize lenses
- Replacement of eyeglass frame and eyeglass lenses furnished under the Vision rider which are lost or broken except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Applicable sales tax charge on vision care services
- 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), Photo-refractive Keratectomy (PRK) and LASIK surgery
- Eyewear except prescription eyewear
- Optional lens extras

Plan Provisions

This is only a general outline of the provisions. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy. Some state exceptions may apply (see State Variations).

Definitions:

- **Dental Benefit Maximum** means the maximum amount payable under the policy for each insured person, per Policy Year, for all dental covered expenses, after the application of any dental benefit deductible and coinsurance.
- **Policy Year** means each consecutive 12 month period beginning with the effective date.

Eligibility

Plans can be issued to a primary insured ages 18 - 99 and spouse/domestic partner (as defined by state) ages 16 - 99. Eligible dependent children include your natural and adopted children and step-children under 26 years of age (or as defined by state).

Age Misstatement

If the age of any insured person has been misstated, our records will be changed to show the correct age. Premium adjustments will be made so that we receive the premiums due at the correct age payable on the premium due date following our notification of an age correction. If the insured person's age has been misstated and we would not have issued coverage for the insured person, we will refund the premium paid minus any benefit amounts paid by us, and coverage will be void from the effective date.

Alternate Procedure

If two or more services are considered acceptable to correct the same dental condition, the amount payable will be based on the covered expenses for the least expensive service that will produce a professionally satisfactory result.

Change of Residence

If you change your residence, we request you notify us.

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 portion covered by the policy has been paid. Network providers have agreed to discounted pricing for covered expenses with no additional billing to you other than the coinsurance and deductible amounts.

Premium Changes

We reserve the right to change the table of premiums on a class basis, as defined in the policy. We will give you written notice of at least 31 days prior to the effective date of the new rates. Each premium will be based on the rate table in effect on the premium due date.

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, as outlined in the policy.

Renewability and Termination of Coverage

The policy is renewable until the earliest of the following:

- Nonpayment of premiums when due, subject to the provisions in the policy
- The end of the premium period following a request by you to terminate the policy
- On the date you: perform an act or practice that constitutes fraud; or make an intentional misrepresentation of material fact, relating in any way to the coverage provided under the policy, including claims for benefits under the policy
- On the date we elect to discontinue this plan, type of coverage, or all coverage in your state
- The date of your death, if it is a primary insured only policy. (If there are other members on the policy, Continuation provisions apply.)

Right to Examine

It is important to us that you are satisfied with the coverage being provided. This product has a Right to Examine period, also commonly referred to as "free look." After applying and after your policy is issued, if you are not satisfied the coverage will meet your insurance needs, you may return the policy to us within 10 days (or as required by state) and have paid premium refunded. Refer to policy for details.

State Variations

Please see below for state availability and applicable state-specific benefits, exclusions and limitations.

Alaska

Form: DEN-CH-GRI-50

- The exclusion for experimental or investigational treatment or complications there from does not apply
- The exclusion for 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 specifies it is as determined by using criteria established in UHC National Standardized Clinical Guidelines, reviewed quarterly and updated at least annually
- In the Premium Changes provision, we will provide at least a 45-day notice of changes
- The Termination of Coverage provision is modified, as follows:
  - If termination is requested by you, termination will be on the date we receive request
  - If we elect to discontinue the plan or type of coverage, we will give you at least 45 days' notice before the date coverage will be discontinued
  - If we elect to discontinue all coverage in your state, we will give you at least 45 days' notice before the date coverage will be discontinued

Arkansas

Form: DEN-CH-GRI-03

- There are no variations

Georgia

Form: DEN-CH-GRI-10

- Major services include TMD (commonly known as TMJ-Temporomandibular Joint/Temporomandibular Disorder) as outlined in the policy.
- For a domestic partner to be eligible for coverage under the policy, you and your domestic partner must attest that you meet the definition of domestic partner as defined in the policy. Domestic partner means a person who: is of the same or opposite gender and who has been living with you in a single, shared residence for at least six months; has a committed, personal relationship with you that is mutually interdependent and intended to be lifelong; agrees to be jointly obligated and responsible with you for each other's necessities; is not married or legally separated from anyone; is 18 years of age or older; is competent to enter into a contract; is not related to you by blood closer than would bar marriage in the state of Georgia; and is your sole partner
- In the Premium Changes provision, we will provide at least a 60-day notice of changes
- In the Termination of Coverage provision:
  - If we elect to discontinue the plan or type of coverage, we will give you at least a 90-day written notice prior to the termination. You will be offered an option to purchase any other similar coverage that we offer without regard to health status
  - If we elect to discontinue coverage in your state, we will give you at least a 180-day written notice prior to the termination
- The Reimbursement provision is replaced with Right of Recovery provision: If you, your spouse or domestic partner has a claim for damages or a right to recover damages from a third party or parties for any dental services for which benefits are payable under the policy, we may have a right of recovery. Our right of recovery shall be limited to the recovery of any benefits paid for identical covered expenses under the policy, but shall not include non-dental items. Money received for future medical care or pain and suffering may not be recovered. Our right of recovery may include compromise settlements. You or your attorney must inform us of any legal action or settlement agreement at least ten days prior to settlement or trial. We will then notify you of the amount we seek to recover for covered expenses paid. Our recovery may be reduced by the pro-rata share of your attorney's fees and expense of litigation.
- There is a 30-day Right to Examine period.

Maine

Form: DEN-CH-GRI-18

- Implant benefits are limited to insured persons over the age of 18 years
- In the Premium Changes provision, we will provide at least a 60-day notice of changes

State Variations continued

Please see below for state availability and applicable state-specific benefits, exclusions and limitations.

Maryland

Forms: DEN-CH-GRI-PBM-19 applies to Plan 1000; DEN-CH-GRI-PBMI-19 applies to Plans 2000 and 3000

- There is an exclusion for services provided as a result of a prohibited health care practitioner referral
- The exclusions for the following do not apply if provided by the Maryland Department of Health:
  - Provided by a government plan, program, hospital or other facility, unless by law an insured person must pay and it is otherwise a covered expense or which by law must be provided by an educational institution
  - Provided without cost to an insured person in the absence of insurance covering the charge
- The exclusion for services provided prior to the effective date or after the termination date of the policy are subject to an Extension of Benefits provision
- The following exclusions don't apply:
  - Any service incurred as a result of the insured 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.
  - Experimental or investigational treatment or for complications there from
  - The insured person taking part in a riot
  - The Insured Person's commission or attempt to commit a felony
- In the definition of eligible dependent, your natural and adopted children and step-children under 26 years of age must be unmarried. In addition, if you or your spouse have a grandchild or a child under testamentary or court-appointed guardianship (other than temporary guardianship of less than 12 months duration) or is: unmarried; is incapable of selfsupport because of mental or physical incapacity before the child, grandchild, or guardianship ordered child attained the limiting age; and is under 26 years of age, the grandchild or guardianship ordered child will also be considered as an eligible dependent
- In the Premium Changes provision, we will provide at least a 40-day notice of changes
- Reimbursement is replaced with Subrogation
- The Age Misstatement provision is revised: If the age of any insured person has been misstated, all amounts payable under the policy shall be such as the premium paid would have purchased at the correct age. If the insured person's age has been misstated and we would not have issued coverage for the insured person, we will refund the premium paid minus any benefit amounts paid by us, and coverage will be void from the effective date.

Ohio

Forms: DEN-CH-GRI-PBM-34 applies to Plan 1000; DEN-CH-GRI-PBMI-34 applies to Plans 2000 and 3000

- Eligible dependents include your lawful spouse/domestic partner and your natural and adopted children, or children placed for adoption, step-children and children for whom you must provide medical support under a court order, who are under 28 years of age
- In the Termination of Coverage provision, if we terminate coverage following a request by you, we will terminate coverage on the date we receive your request or a later date, if specified
- In the Reimbursement provision, if the insured person is not fully compensated by any recovery received by third party due to comparative negligence, reduction of the third party's liability, limited liability insurance, or any other cause, our claim shall be reduced in the same proportion as the insured person's interest is diminished

Note to our customers about supplemental insurance

- The supplemental plan discussed in this document is separate from any health insurance or Medicare Advantage coverage you may have purchased with another insurance company
- This plan provides optional coverage for an additional premium. It is intended to supplement your health insurance and provide additional benefits for covered expenses.
- This plan is not required in order to purchase health insurance with another insurance company
- This plan should not be used as a substitute for comprehensive health insurance coverage. It is not considered Minimum Essential Coverage under the Affordable Care Act.

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.

VIEW NOTICE HERE. Please review it carefully.
(https://www.uhc.com/content/dam/uhcdotcom/en/npp/NPP-UHC-EI-UHOne-EN.pdf)

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 Companyy exactly as applied for within 45 days from date of application; (b) delivered to the proposed insured; and (c) accepted by the proposed insured

After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded. Keep an electronic copy of this document. It has important information.

50339-G-1224

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