DentalWise Max

DentalWise® Max plans are dental, vision and hearing 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., Vision benefits - Spectera, Inc., and Hearing benefits - UnitedHealthcare Hearing.

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

UnitedHealthcare®
Golden Rule Insurance Co.

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Dental, vision, hearing (DVH) highlights

Coverage for your oral, eye and hearing 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.

Help with hearing aids, including over-the-counter

Hearing loss is an invisible problem that can affect your social life, safety and overall well-being. Our DentalWise Max plans offer benefits provided through UnitedHealthcare Hearing providers, which has straight-forward benefits for annual hearing exams and coverage for hearing aids, and also includes over-the-counter (OTC) hearing aids, when you use a network provider.

Why dental, vision and hearing insurance?

Taking care of your health goes beyond regular medical checkups. Dental, vision and hearing 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, vision and hearing care. When you smile more, and can hear 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.

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.

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 and hearing benefits are included (see pages 6-9 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). Non-network dentists can bill a patient for any remaining amount up to the billed charge. [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.

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, 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.

Hearing plan benefits

These hearing benefits, through UnitedHealthcare Hearing network providers, are included with your DentalWise Max plan, regardless of the dental plan you choose.

Hearing benefits per insured person

Hearing waiting period	None
Hearing exam[1] Coverage for routine hearing exam once per Policy Year[2]	We pay 100%
Hearing aid(s)[1] Once every 2 Policy Years towards prescription or over-the-counter (OTC) hearing aids. Prescription hearing aid(s) include a fitting appointment with an in-network provider.	We pay up to a $750 allowance

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

[1] Benefits are per person and not per ear. Hearing benefits are available only for covered expenses incurred at, or purchased over-the-counter from, a UnitedHealthcare Hearing Network provider. [2] Policy Year means each consecutive 12 month period beginning with the effective date.

Hearing benefit access

Hearing benefits and how they work

Hearing benefits are administered by UnitedHealthcare Hearing. We will cover hearing services subject to the terms, conditions, exclusions and limitations of the policy and Hearing Benefit Rider SA-S-2099-CH-GRI and other state variations. (See State Variations for details.)

Hearing benefits are provided through UnitedHealthcare network providers only

You can begin your journey by contacting UnitedHealthcare Hearing at **1-844-571-4958** or visiting **uhchearing.com/gric**. Here you can learn more about hearing care and hearing aid options, find an in-network provider and request a no-cost hearing test appointment. You'll work with a hearing provider to select and purchase a prescription hearing aid that will be a good fit for your needs and lifestyle. Plus, you'll have access to follow-up support from your provider.

Over-the-counter (OTC)* hearing aids are also covered when purchased online through UnitedHealthcare Hearing. A hearing test is not required for OTC hearing aids and follow-up support may vary. Explore our selection of audiologist-approved OTC hearing aids by visiting **uhchearing.com/gric**.

Purchasing through UnitedHealthcare Hearing does not require a claim submission. You are responsible for any amount in excess of the hearing benefit allowance or frequency in the policy.

*OTC hearing aids are intended for individuals over the age of 18 with self-diagnosed mild-to-moderate hearing loss. If you have questions about your degree of hearing loss, it is recommended you meet with a licensed hearing provider.

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

Hearing Exclusions and Limitations

Covered hearing 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
- Services received by a hearing non-network provider
- Assistive listening devices (ALDs)
- For medical and/or surgical treatment of the internal or external structures of the ear provided by an audiologist, hearing aid dispenser, or physician
- Ear protection devices or plugs
- Replacement due to loss, theft, or damage to the hearing aid
- Hearing aid maintenance including batteries, maintenance/service contracts, fittings, ear molds and other miscellaneous repairs

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.

Alabama

Form: DEN-CH-GRI-01

- There are no variations

Arizona

Form: DEN-CH-GRI-02

- The exclusion for services provided by an immediate family member or someone who ordinarily resides with an insured person does not apply
- The Reimbursement provision does not apply

Connecticut

Form: DEN-CH-GRI-06

- The exclusion for intoxication or drug use applies to any service incurred by voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless administered or prescribed by a physician or voluntary taking of any over the counter drug unless taken in accordance with the manufacturer's recommended dosage
- The limiting age for dependent children is 27
- The Reimbursement provision does not apply
- There is a 30-day Right to Examine period

Delaware

Form: DEN-CH-GRI-07

- There are no variations

District of Columbia

Form: DEN-CH-GRI-08

- Eligible dependent means your spouse/domestic partner or civil union partner (as defined in the policy), civil union partner's dependent and your natural and adopted children and step-children who are under 26 years of age. It also includes your minor grandchild, niece, or nephew for whom you provide food, clothing, and shelter on a regular and continuous basis during the time that the District of Columbia public schools are in regular session, if the legal guardian of such minor grandchild, niece, or nephew is not covered by another accident or sickness policy

Florida

Form: DEN-CH-GRI-09

- The exclusion regarding workers' compensation is revised: which arise out of, or in the course of, employment for wage or profit, if the insured person is insured by workers' compensation insurance pursuant to the applicable state or federal law and the services are paid for by workers' compensation
- Eligible dependent is expanded to include foster children. The limiting age for dependent children is 31 years of age.
- In the Premium Changes provision, we will provide at least a 45-day notice of changes
- Termination of Coverage provision is revised: Your coverage will terminate and no benefits will be payable under the policy and any attached riders, if any, on the earliest of:
  - Nonpayment of premiums when due, subject to the provisions in the policy;
  - Upon our receipt of your request of termination;
  - As of the date you present a claim containing any false, incomplete or misleading information concerning any fact or thing material to such claim provided we give you at least 45 days written notice prior to terminating coverage;
  - As of the policy effective date, as if coverage never existed, in the event that facts material to the application for coverage are false, incomplete or misleading provided we have given you at least 45 days written notice prior to terminating coverage;
  - On the date we elect to discontinue this plan or type of coverage. We will give you at least 90 days' notice before the date coverage will be discontinued. You will be offered an option to purchase any other similar coverage that we offer without regard to health status;
  - On the date we elect to discontinue all coverage in your state. We will give you and the proper state authority at least 180 days' notice before the date coverage will be discontinued; or
  - The date of your death, if this is a primary insured only policy

Hawaii

Form: DEN-CH-GRI-51

- Eligible dependent is expanded to include your Reciprocal Beneficiary. Reciprocal Beneficiary means an adult who along with another adult are parties to a valid Reciprocal Beneficiary relationship and meets the following requisites for a valid Reciprocal Beneficiary relationship: (A) each of the parties be at least eighteen years old; (B) neither of the parties be married, a party to another Reciprocal Beneficiary relationship, or a partner in a civil union; (C) the parties be legally prohibited from marrying one another under HAW. REV. STAT. §572; (D) consent of either party to the Reciprocal Beneficiary

State Variations continued

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

Hawaii (continued)

relationship has not been obtained by force, duress, or fraud; and (F) each of the parties sign a declaration of Reciprocal Beneficiary relationship as provided in section HAW. REV. STAT. §572C-5.

Idaho

Form: DEN-CH-GRI-11

- The exclusion for services as the result of a felony does not apply to an attempt. It only applies to commission of a felony
- Eligible dependent is expanded to include an unmarried child of any age who is medically certified as disabled or dependent upon you

Indiana

Form: DEN-CH-GRI-13

- Eligible dependent means:
  - Your lawful spouse/domestic partner
  - Your natural children who are under 26 years of age
  - Your adopted children, upon the earlier of the date of placement for the purpose of adoption or the date of entry of an order granting the adoptive parent custody of the child for the purpose of adoption, unless the placement is disrupted prior to legal adoption and the child is removed from placement, who are under 26 years of age
  - Your step-children who are under 26 years of age
  - A child for whom legal guardianship has been awarded to you or your spouse who are under 26 years of age
- There is a 30-day Right to Examine period

Iowa

Form: DEN-CH-GRI-14

- The exclusion for services when the insured person commits or attempts to commit a felony applies only if the person is being charged with the commission or attempt to commit a felony
- There is a 30-day Right to Examine period

Kansas

Form: DEN-CH-GRI-15

- In the exclusion regarding workers' compensation, if an insured person enters into a settlement that waives an insured person's right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for the insured person's workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by the agency.
- The Reimbursement provision does not apply
- In the Termination of Coverage provision, if you provide a written notice to terminate the policy, it is effective upon receipt of the notice or a later date as specified in the notice

Kentucky

Form: DEN-CH-GRI-16

- In the Premium Changes provision, the premium table will not be increased within 12 months from date of issue or date of renewal
- 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

Louisiana

Form: DEN-CH-GRI-17

- Eligible Dependent means your lawful spouse/domestic partner and your natural and adopted children (children placed in your home following execution of an act of voluntary surrender), step-children and grandchildren (in legal custody of grandparent) who are under 26 years of age
- In the Premium Changes provision, we will provide at least a 45-day notice of changes. Rates will not increase more than once each 6-month period, following the initial 12-month period
- In the Termination of Coverage provision, if we discontinue the plan or type of coverage, we will provide written notice at least 60 days prior to discontinuance
- There is a 30-day Right to Examine period

Michigan

Form: DEN-CH-GRI-21

- The following exclusions do not apply:
  - Any service incurred 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

State Variations continued

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

Michigan (continued)

- Intentionally self inflicted bodily harm
- The insured person taking part in a riot

- The exclusion any act of declared or undeclared war applies while serving in the military or naval services, or any auxiliary unit of the United States
- The exclusion for felony excludes services due to the insured person's committing or attempting to commit a misdemeanor or felony, whether or not charged or being engaged in an illegal occupation; other willful criminal activity was a contributing cause

Mississippi

Form: DEN-CH-GRI-23

- In the Premium Changes provision, we will provide at least a 75-day notice of changes
- The Age Misstatement provision is revised: If the age of the 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

Missouri

Form: DEN-CH-GRI-24

- 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
- The Reimbursement provision does not apply

Nebraska

Form: DEN-CH-GRI-26

- Eligible dependent is expanded to include children placed for adoption
- In the Reimbursement provision, our right to be repaid applies only after the insured person is fully compensated for the loss

Nevada

Form: DEN-CH-GRI-27

- The exclusion does not apply for any service incurred 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
- The exclusion for felony applies only when the insured is being convicted of a felony and does not apply if the insured is the victim of domestic violence, regardless of whether the insured contributed to any loss or injury
- In the Premium Changes provision, we may change the premium with approval by the Division of Insurance, provided we have given at least a 60-day written notice prior to the change
- The Reimbursement provision does not apply

New Hampshire

Form: DEN-CH-GRI-28

- The exclusion for services incurred as a result of insured person being intoxicated or under the influence of illegal narcotics or controlled substance is replaced with: The voluntary consumption of drugs that are not prescribed by the insured person's physician or used in the manner intended or felonious driving while intoxicated by alcoholic substances
- The exclusion regarding worker's compensation is replaced with: Treatment provided in a government hospital, benefits provided under Medicare or other governmental program (except Medicaid), a state or federal workers' compensation, employers' liability or occupational disease law services rendered by employees of hospitals, laboratories or other institutions
- The exclusion for commission of a felony applies, but the exclusion for an attempt to commit a felony does not apply
- The exclusion for services provided by a government plan, program, hospital or other facility does not apply
- The exclusion for services provided by someone who ordinarily resides with the insured person does not apply, but the exclusion still applies for services provided by an immediate family member
- Eligible dependent includes your lawful spouse/domestic partner and your children by blood or by law who are under 26 years of age
- The Alternate Procedure provision does not apply
- The Reimbursement provision does not apply
- In the Termination of Coverage provision:
  - If coverage is terminated due to non-payment of premium, we will give you at least 30 days after the date of our mailing the written notice accompanied by the reason for the termination
  - If you provide a request to terminate the policy, it is effective on the date we receive your request.
- There is a 30-day Right to Examine period

State Variations continued

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

North Carolina

Form: DEN-CH-GRI-32

- Major services include dental services and procedures for congenital defects or anomalies, including all necessary treatment and care needed by your covered dependent(s) born with cleft lip or cleft palate
- The exclusion does not apply for 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
- The exclusion related to services which arise out of, or in the course of, employment for wage is revised to: Services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act
- The exclusion for any act of declared or undeclared war does not apply to terrorism
- Eligible Dependent Child means your natural, adopted, step, or foster:
  - Child who is under 26 years of age; or
  - Child who is over 26 years of age and incapable of self-sustaining employment by reason of mental retardation or physical handicap; and chiefly dependent on you for support and maintenance

  Additionally, if you are required under a court or administrative order to provide insurance coverage to a child, such child will be considered an eligible dependent so long as they meet the criteria above
- In the Premium Changes provision, the table of premiums for this policy are guaranteed to not change for 12 months from the effective date of coverage. After that, we will provide a 45-day notice of any changes. New rates are guaranteed for a period of no less than 12 months
- The Reimbursement provision does not apply
- In the Termination of Coverage provision, the following revisions are made:
  - If we terminate you based on an intentional misrepresentation of material fact, it must be within 2 years of the effective date of coverage
  - If we terminate you on the date we elect to discontinue the plan or type of coverage, we will provide you with a 180 day notice in the event we terminate the plan
  - If we terminate you on the date we elect to discontinue all coverage in your state, we will provide you with a 180 day notice in the event we terminate the plan
- There is a 30-day Right to Examine period

North Dakota

Form: DEN-CH-GRI-33

- Eligible dependent is expanded to include dependents of covered dependents

Oklahoma

Form: DEN-CH-GRI-35

- The exclusions for services as a result of intoxication or voluntary taking of over the counter drugs do not apply. However, the exclusion for any services sustained while under the influence of illegal narcotics or controlled substance unless administered or prescribed by a physician still applies.
- The exclusion for any act of declared or undeclared war applies while serving in the military or any auxiliary unit attached to the military or working in an area of war whether voluntary or as required by an employer; participation in a felony, riot or insurrections, service in the armed forces or units auxiliary thereto

Pennsylvania

Form: DEN-CH-GRI-37

- The Reimbursement provision is revised: If an insured person's dental services are caused by the acts or omissions of a third party, we will not cover a loss to the extent that it is paid as part of a settlement or judgment by any third party. However, if payment by or for the third party has not been made by the time we receive acceptable proof of loss, we will pay regular policy benefits for the insured person's loss. We will have the right to be reimbursed if the insured person subsequently receives any payment from any third party for dental claims. The insured person (or the guardian, legal representatives, estate, or heirs of the insured person) shall promptly reimburse us from the settlement, judgment, or any payment received from any third party.

State Variations continued

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

South Carolina

Form: DEN-CH-GRI-39

- For plans that cover major services, the following will be considered as covered major services when received by your covered dependent for the care and treatment of cleft lip and cleft palate, as defined in the policy:
  - Diagnostic cephalometric film;
  - Limited orthodontic treatment of the primary, transitional, adolescent, or adult dentition;
  - Interceptive orthodontic treatment of the primary or transitional dentition;
  - Comprehensive orthodontic treatment of the transitional, adolescent, or adult dentition;
  - Removable appliance therapy; and
  - Pre-orthodontic treatment visit
- There is a 30-day Right to Examine period

South Dakota

Form: DEN-CH-GRI-40

- The exclusion does not apply for any service incurred 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
- The exclusion for workers' compensation is revised: Benefits which are paid under any workers' compensation insurance pursuant to the applicable state or federal law
- The exclusion for services provided by an immediate family member does not apply if they are the only provider within 50 miles and are acting within the scope of their license
- The exclusion for teeth that are not periodontally sound does not apply. The exclusion still applies for teeth that have a questionable prognosis as determined by us
- In the exclusions that reference natural teeth, "natural" does not apply

Tennessee

Form: DEN-CH-GRI-41

- In the exclusion for services provided prior to the effective date or after the termination date of the policy, if a specific treatment is started while an insured person is insured under the policy, we will pay benefits for covered dental services which are completed within 31 days after your termination date
- Eligible dependent is expanded to include your children primarily dependent upon you for financial support and maintenance and your children for whom coverage has been ordered by a court of law or administrative order who are under 26 years of age
- In the Reimbursement provision, we have the right to be reimbursed to the extent of benefits we paid for the dental services if the insured person subsequently receives any payment from any third party, but only after the insured person is fully compensated for his or her loss
- In the Termination of Coverage provision, if we discontinue plan, type of coverage, or coverage in your state, we will give you at least 30 days' notice before the date coverage will be discontinued

Texas

Form: DEN-CH-GRI-42

- The exclusion for services provided by an immediate family member or someone who ordinarily resides with an insured person does not apply
- Eligible dependent is expanded to include: your or your spouse's children for whom you or your spouse are a party in a suit for which adoption is sought; children for whom you must provide medical or dental support under a court order; your grandchildren who are dependent on you for the purposes of Federal Income Tax at the time of application and who are under 26 years of age; and dependents 26 and over who are incapable of self- sustaining employment by reason of mental retardation or physical handicap and chiefly dependent on you for support and maintenance

Utah

Form: DEN-CH-GRI-43

- The exclusion for intoxication and substance abuse is revised: Any service incurred as a direct result of the insured person being found guilty of voluntarily participating in an illegal activity while being intoxicated, as defined by applicable state law in the state in which the loss occurred, or being found guilty of voluntarily participating in an illegal activity while under the influence of illegal narcotics or controlled substance unless administered or prescribed by a physician or voluntary taking of any over the counter drug unless taken in accordance with the manufacturer's recommended dosage
- The exclusions for insured person taking part in a riot or insured person's commission or attempt to commit a felony apply only if done voluntarily

State Variations continued

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

Utah (continued)

- The exclusion for reconstructive surgery does not apply when the service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part or reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect
- The exclusions regarding congenital malformation and congenital anomalies do not apply
- Eligible dependent is expanded to include children placed for adoption or legally adopted, foster children, and children for whom a parent is required by a court or administrative order to provide dental coverage for
- In the Premium Changes provision, we will provide written notice at least 45 days prior to any rate changes. Your premium rates may be adjusted based on a new requirement under state or federal law or when a change in any existing state or federal requirement becomes effective which applies to the policy. We will make no change in your premium solely because of claims made under the policy or a change in an insured person's health. While the policy is in force, we will not restrict coverage already in force.
- There is a 30-day Right to Examine period

Vermont

Form: DEN-CH-GRI-44

- The waiting period for Implants is 6 months
- The exclusion for covered expenses incurred during the Waiting Period does not apply to a dental emergency, as defined in the policy
- The exclusion does not apply for 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 does not apply
- Spouse is expanded to include your civil union partner established under Vermont law
- In the Termination of Policy provision, termination related to fraud is based on the date you perform an act or practice that results in a fraud conviction
- There is a 30-day Right to Examine period

Virginia

Form: DEN-CH-GRI-45

- The exclusion for intoxication or being under the influence is revised: Any service incurred as a result of the insured person being drunk or under the influence of any narcotics unless taken on the advice of a physician
- The exclusion for experimental or investigational treatment does not apply
- In the exclusion for services 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, coverage for any medical condition will not be excluded if an award of the Workers' Compensation Commission denied compensation benefits relating to such medical condition and no request for review of such award is made within 30 days or an award of the Workers' Compensation denies compensation benefits relating to such medical condition
- The exclusion for any act of declared or undeclared war does not apply to terrorism
- The exclusion for services provided by an immediate family member does not apply to services provided by someone who ordinarily resides with insured person that is not immediate family
- The exclusion for reconstructive surgery does not apply when the surgery is incidental to a dental disease or injury when the primary purpose is to improve physiological functioning of the involved part of the body
- The exclusions for congenital malformation or congenital anomalies do not apply
- The exclusion for treatment of benign neoplasms, cysts, or other pathology involving benign lesions, does not apply when benefits are provided under the Oral Surgery benefit outlined in the policy
- The exclusions for photographs or diagnostic casts do not apply
- In the exclusion, where applicable, for initial placement of full or partial dentures or bridges and related services, to replace functional natural teeth, the teeth are not required to be congenitally missing or lost before insurance under the policy is in effect
- The exclusion for charges for dental services that are not documented is revised to: Charges for dental services that are not documented in the dentist records, that are not directly associated with dental disease or preventive covered expenses, or that are not performed in a dental setting

State Variations continued

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

Virginia (continued)

- The exclusion for bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous does not apply if specifically listed as Periodontics and Oral Surgery benefits outlined in the policy
- The exclusion for surgical extractions of wisdom teeth does not apply as allowed under Oral Surgery in the policy
- In the Termination of Contract provision, coverage will terminate and no benefits will be payable to you under the policy and any attached riders, if any, on the earliest of:
  - Nonpayment of premiums when due (subject to the Grace Period);
  - On the renewal date We elect to discontinue this plan or type of coverage;
  - On the renewal date We elect to discontinue all coverage in Your state; or
  - The date of Your death, if this is a primary insured only Policy
- The Reimbursement provision does not apply
- The Age Misstatement provision is revised: If the age of any insured person has been misstated, the benefits will be those the premium paid would have purchased at the correct age. If the age of the insured person has been misstated, and if according to the correct age of the insured person, the coverage provided by the policy would have become effective or would have ceased prior to the acceptance of the premium, then our liability will be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

West Virginia

Form: DEN-CH-GRI

- There are no variations

Wisconsin

Form: DEN-CH-GRI-48

- An Outline of Coverage for this state, DEN-CH-OC-GRI-48, can be viewed at **https://stage.uhone.com/api/supplysystem/?Filename=50338OCWI-G202401.pdf**
- Eligible dependent child includes a child of you or your spouse/domestic partners dependent child, while that dependent child is under 18.
- In the Premium Changes provision, we will provide at least a 60-day notice of changes

Wyoming

Form: DEN-CH-GRI-49

- Eligible dependent is expanded to include children of a non-custodial parent, or a parent sharing custody or temporary control pursuant to a court order
- **This policy does not contain comprehensive adult wellness benefits as defined by Wyoming Law**

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 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

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.

50338-G-1224

UnitedHealthcare®
Golden Rule Insurance Co.