

Dental Gen Plans

Plans[1] For Individuals 64+

(hearing benefit[2] included with option to add vision benefits[3]

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

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

[1] Plans may differ by zip code.
[2] The hearing benefit is not available in WA.
[3] The optional vision benefit is not available in MN, RI or WA.

UnitedHealthcare®
Golden Rule Insurance Co.

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.

45587B-G-0926

Helping to Enhance Your Quality of Life

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





PREVENTIVE - BASIC - MAJOR

NO WAITING PERIODS[1]

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



INCLUDED COVERAGE

HEARING AIDS/EXAMS[2]

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



OPTION TO ADD

VISION BENEFIT[3]

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

96% of US adults
aged 65+ have had a cavity.
— cdc.gov Center for Disease Control, May 2024

NETWORK SAVINGS

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

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

[2] Hearing benefit not available in WA.

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

[4] UHC Specialty Benefits interal data 2023

Gen Saver[1,2]

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

Our Lowest Premium

Preventive Care Services (includes routine cleaning & exams)	**Policy pays 60% day one** 70% after policy year one 80% after policy year two
	After Deductible:
Basic Services (includes simple fillings & extractions)	**Policy pays 50% day one** 65% after policy year one 80% after policy year two
Major Services (includes crowns, root canals, oral surgery, and bridges)	**Policy pays 10% day one[4]** 40% after policy year one[4] 50% after policy year two
Coverage Amount (per calendar year)	**$1,000 annual maximum**
Deductible (per calendar year, family max 3 deductibles per service type)	**$100 per person** (combined basic and major services)
Most Valuable Feature	**Our Lowest Premium** of Dental Gen plans

Gen Plus[3,2]

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

Use Any Dentist

Preventive Care Services (includes routine cleaning & exams)	**Policy pays 60% day one** 70% after policy year one 80% after policy year two
	After Deductible:
Basic Services (includes simple fillings & extractions)	**Policy pays 50% day one** 65% after policy year one 80% after policy year two
Major Services (includes crowns, root canals, oral surgery, and bridges)	**Policy pays 10% day one[4]** 40% after policy year one[4] 50% after policy year two
Coverage Amount (per calendar year)	**$1,000 annual maximum**
Deductible (per calendar year, family max 3 deductibles per service type)	**$100 per person** (combined basic and major services)
Most Valuable Feature	**Network Flexibility** of higher non-network benefits

Comparing Non-Network vs. Network[5]

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

[1] Pays non-network provider benefits based on the network negotiated rate. [2] Non-network dentists can bill a patient for any remaining amount up to the billed charge. [3] Pays non-network provider benefits based on the reasonable and customary charge. [4] In CT & IL, after a 6-month waiting period, Major Services pays 50% and remains 50% after year one. [5] Service pricing in ZIP Code 752– using policy year one and assuming the plan deductible has been met. Discounts vary by policy year, type of provider, geographic area, and type of service.

PREVENTIVE - BASIC - MAJOR
NO WAITING PERIODS[4]

INCLUDED COVERAGE
HEARING AIDS/EXAMS

OPTION TO ADD
VISION BENEFIT

Gen Basic[1]

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

100% Preventive Coverage

Preventive Care Services (includes routine cleaning & exams)	**Policy pays 100% day one**
	After Deductible:
Basic Services (includes simple fillings & extractions)	**Policy pays 50% day one** 65% after policy year one 80% after policy year two
Major Services (includes crowns, root canals, oral surgery, and bridges)	**Policy pays 10% day one[2]** 40% after policy year one[2] 50% after policy year two
Coverage Amount (per calendar year)	**$1,500 annual maximum**
Deductible (per calendar year, family max 3 deductibles per service type)	**$100 per person** (combined basic and major services)
Most Valuable Feature	**Policy pays 100%** for Preventive Care Services & Higher Annual Max

Gen Deluxe[1]

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

Covered Dental Implants

Preventive Care Services (includes routine cleaning & exams)	**Policy pays 100% day one**
	After Deductible:
Basic Services (includes simple fillings & extractions)	**Policy pays 50% day one** 65% after policy year one 80% after policy year two
Major Services (includes dental implants, crowns, root canals, oral surgery, and bridges)	**Policy pays 10% day one[2]** 40% after policy year one[2] 50% after policy year two
Coverage Amount (per calendar year)	**$2,000 annual maximum**
Deductible (per calendar year, family max 3 deductibles per service type)	**$50 per person** (combined basic and major services)
Most Valuable Feature	**Dental Implant Coverage** & Highest Annual Max

Comparing Non-Network vs. Network[3]

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

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

PREVENTIVE - BASIC - MAJOR
NO WAITING PERIODS[2]

INCLUDED COVERAGE
HEARING AIDS/EXAMS

OPTION TO ADD
VISION BENEFIT

INCLUDED COVERAGE

HEARING AIDS/EXAMS

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

UnitedHealthcare Hearing KEY FEATURES

- **Over 7,000 hearing providers nationwide**[1]
- **Hearing exams and hearing aid evaluations**
- **Name-brand and private-labeled hearing aids**
- **Order hearing aids in person or through home delivery**

FIXED BENEFITS WHAT POLICY PAYS

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

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

Learn more about UnitedHealthcare Hearing discounts: uhchearing.com/GRIC



Hearing Benefit Example

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

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

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

[1] 2023 UnitedHealthcare internal data.

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

OPTION TO ADD

VISION BENEFIT[1]

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

COVERED EXPENSES
WHAT YOU PAY

Eye Exam Once every 12 months	**Network**	$10 copay
	Non-network	Any charge over $50 allowance
plus, either Glasses *or* Contacts:[3]		
Eyeglass Frames[4] Once every 12 months	**Network**	Any charge over $150 allowance
	Non-network	Any charge over $75 allowance
Eyeglass Lenses One pair every 12 months (of any type)[4]	**Network**	$10 copay
	Non-network	Any charge over: $40 allowance (Single Vision); $60 allowance (Bifocal); $80 allowance (Trifocal/Lenticular)
Contacts Once every 12 months	**Network**	Select Contact Lenses List[5]: $0 Copay Non-Selection Contacts: Any charge over $150 allowance
	Non-network	Any charge over $105 allowance



Optional Vision Benefit Example

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

Our network includes private practices along with leading retail locations. Choose from network providers by visiting myuhcvision.com.

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

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

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

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

[3] Select either eyeglasses (lenses and/or frames) or contacts, not both.

[4] See eyeglass frames and lens coverage details on page 11.

[5] If you choose disposable contacts, up to 4 or 6 boxes, depending on frequency of wear, are included when obtained from an in-network provider.

Administered by Spectera, Inc. Policy Form SA-S-1882-GRI
The people and events depicted here are fictional and do not represent actual cases.

Other Details
(all dental plans)

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

This brochure may be used in the following states:

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

Basic Policy Details

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

All Plans: Preventive Services

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

All Plans: Basic Services

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

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

- Root canals – limit 1 time per tooth, per lifetime.
- Periodontal maintenance – limited to 2 per calendar year.
- Crowns – limit 1 per tooth, per 60 months.
- Surgical extraction of erupted tooth or roots – limited to 1 time per tooth per lifetime.
- Full dentures – limited to 1 per 60 months.
- Bridges – limited to 1 time per tooth, per 60 months.
- Repairs to crowns, dentures and bridges.
- Inlays/onlays – limit 1 per tooth, per 60 months.

Gen Deluxe Plans only: Implants

Implants are covered under Major Services and subject to the annual maximum – 1 time per tooth per 60 months.

Calendar Year vs. Policy Year

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

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

Change or Misstatement of Residence (Address)

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

Eligibility

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

Other Details
(all dental plans)

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

Misstatement of Age

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

Non-Network vs. Network

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

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

Premium

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

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

Reimbursement

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

Renewability and Termination

The policy is renewable until the earliest of the following:

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

General Exclusions and Limitations

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

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

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

Other Details
(all dental plans)

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

General Exclusions and Limitations, continued

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

- Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies, including but not limited to, take-home fluoride; prescription and non-prescription drugs, unless they are dispensed and utilized in the dental office during a covered person's dental visit; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures.
- Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis.
- Acupuncture, acupressure, and other forms of alternative treatment.
- Telephone consultations or for failure to keep a scheduled appointment.
- Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations).
- Any dental services which result from intoxication, as defined by applicable state law in the state where the loss occurred, or under the influence of illegal narcotics or controlled substance, unless administered or prescribed by a doctor.
- Experimental or investigational treatment or for complications there from. (does not apply in VA)
- Any dental service which results from or in the course of your employment for wage or profit (CA, FL, NC – applies if paid by worker's compensation).
- Any dental service which results from any act of war, participation in a riot, intentionally self-inflicted bodily harm, or commission or attempt to commit a felony.
- Maxillofacial prosthetics and related services; reconstructive surgery.
- Provided free of charge without this insurance or provided by a government plan, program, hospital or other facility unless by law you must pay.
- Any dental service provided by a family member or by someone who ordinarily resides with a covered person. (Does not apply in TX. Does not apply in SD if household member is only provider in 50 mile radius. Someone who ordinarily resides with a covered person does not apply in VA.)
- Any dental service received outside of the United States, except for a dental emergency.
- Related to temporomandibular joint, upper and lower jaw bone surgery, or orthognathic surgery (does not apply in MN).
- Any dental service relating to teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis.
- Orthodontia, braces, cosmetic dentistry, and any related procedure.
- Dental implants and any related procedure, unless included in your plan.
- Oral surgery, except as expressly provided for in the policy.
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal; treatment of malignant neoplasms or congenital anomalies.
- Mouthguards, precision or semi-precision attachments, occlusal guards, bruxism appliances, duplicate dentures, harmful habit appliances, replacement of lost or stolen appliances, or sleep disorder appliances.
- Provided as a result of a prohibited referral (MD only).

Other Details
(all dental plans)

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

General Exclusions and Limitations, continued

For Major Services, no benefits are payable for:

- Initial placement of full or partial dentures or bridges and related services, to replace functional natural teeth that are:
  - Congenitally missing; or
  - Lost before insurance under the policy is in effect.
- Replacement of full or partial removable dentures, bridges, crowns, inlays, onlays, or veneers which can be repaired or restored to natural function.
- Replacement within 60 consecutive months of the last placement for full and partial dentures, crowns, bridges, inlays, onlays, and veneers.
- Replacement of crowns, bridges, dentures, fixed or removable prosthetic appliances, implants, implant crowns, implant prosthesis and implant supporting structure inserted prior to plan coverage unless the covered person has been insured under the plan for 12 continuous months.
- Replacement of complete dentures, fixed and removable partial dentures, crowns, implants, implant crowns, implant prosthesis and implant supporting structure if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the dentist. If replacement is necessary because of your or your dependents' non-compliance, you are liable for the cost of the replacement.
- Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- Placement of fixed partial dentures solely to achieve periodontal stability.

Vision Details
(optional benefit)

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

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

Vision Program Works

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

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

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

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

Eyeglass Frames and Lenses

This rider includes a benefit to receive eyeglass frames and lenses OR contacts every 12 months. The eyeglass frames benefit includes their fitting and subsequent adjustments to maintain comfort and efficiency. Eyeglass lenses may include single vision, bifocal, and trifocal/ lenticular lenses. Additional costs for other types of lenses, lens materials and lens option extras may apply.

Vision Benefit Exclusions and Limitations

No benefits are payable for the following vision expenses:

- Orthoptics or vision therapy training and any associated supplemental testing;
- Plano lenses (a lens with no prescription on it);
- Oversized lenses;
- Replacement of eyeglass lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination or any corrective eyewear, required by an employer as a condition of employment (does not apply in AK);
- Corrective vision treatment of an experimental or investigative nature (does not apply in AK);
- Corrective surgical procedures such as, but not limited to, Radial Keratotomy (RK) and Photorefractive Keratectomy (PRK);
- Elective contact lenses if prescription eyeglass lenses and frames are received in any 12-month period;
- Prescription eyeglass lenses and frames if elective contact lenses are received in any 24-month period;
- Eyewear except prescription eyewear;
- Charges that exceed the allowed amount;
- Services or treatments that are already excluded in the General Exclusions and Limitations section of the policy; and
- Optional lens extras not listed in your policy.

Find a vision provider by clicking here: myUHCvision.com

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.

UnitedHealthcare®
Golden Rule Insurance Co.

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45587-G-0926