Dental Premier Plans

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

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

Policy Forms GRI-DEN3-JR, -01 (AL), -02 (AZ), -03 (AR), -04 (CA), -05 (CO), -06 (CT), (DE), -08 (DC), -09 (FL), -10 (GA), -51 (HI), -12 (IL), -13 (IN), -14 (IA), -15 (KS), -16 (KY), -17 (LA), -18 (ME), -19 (MD), -21 (MI), -22 (MN), -23 (MS), -24 (MO), -26 (NE), -28 (NH), -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), and -48 (WI); GRI-DEN3-JR-PB, -11 (ID), -34 (OH), -46 (WA); GRI-DEN3-JR-PBM, -11 (ID), -34 (OH), -46 (WA); GRI-DEN3-JR-PBM-IO-46 (WA)

UnitedHealthcare®
Golden Rule Insurance Co.

[1] Premier Choice and Premier Plus are the only plans available in ME.

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

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.

45586C1WI-G-0125 (includes 45586-G-0125 and 45631-G-1018)

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

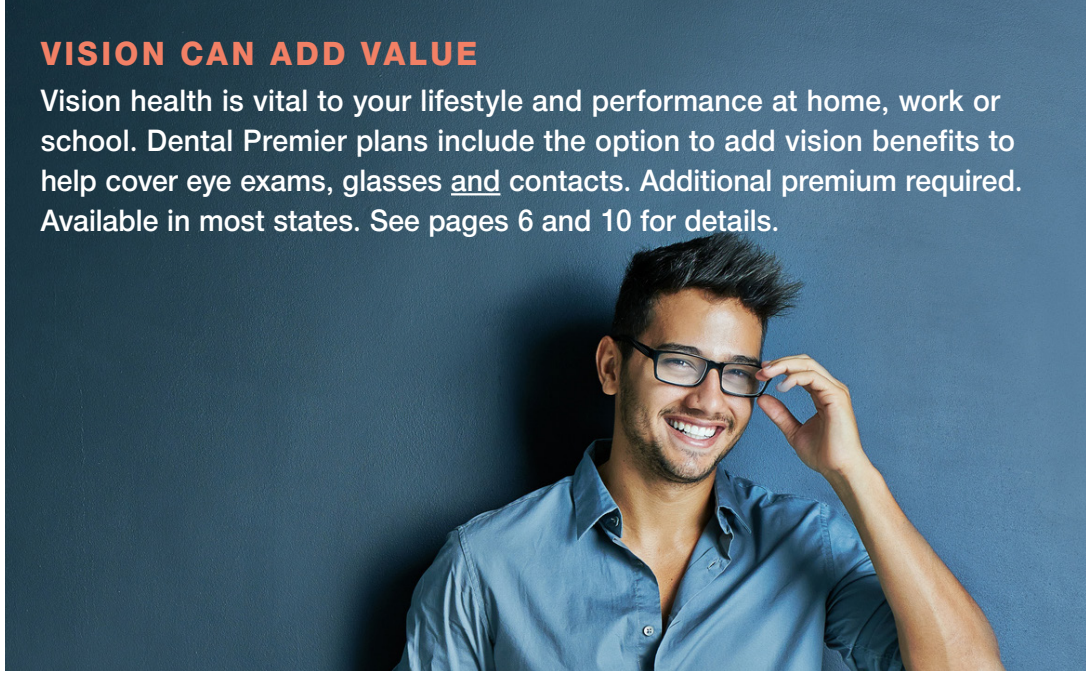
Life can be more enjoyable when you feel comfortable with your smile and can see and hear the world around you.

DENTAL PLANS FOR THE FAMILY

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

VISION CAN ADD VALUE

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



HEARING AID DISCOUNTS*

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

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

Premier Choice

Designed to offer immediate coverage[1] and network discounts for preventive care, basic and major services.

Lower Premium

Preventive Care Services (includes routine cleaning & exams)	**Policy pays 100% day one**
	After Deductible:
Basic Services (includes simple fillings & extractions)	**Policy pays 50% day one** 65% after policy year one 80% after policy year two
Major Services (includes crowns, root canals, oral surgery & bridges)	**Policy pays 10% day one[1]** 40% after policy year one[1] 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)	**$50 per person** (combined basic & major services)
Most Valuable Feature	**No Waiting Periods[1]**

All plans pay 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.

ALL PLANS

$0
Routine Cleaning (Network, day one)

Retail Charge for adult without plan: $95.47

Network Pricing Over Time[2]	Retail charge	During policy year:	Premier Choice year one	Premier Choice year two
Simple Filling	**$181.14**	You pay:	**$28.50**	**$19.95**
Molar Root Canal	**$1,255.36**	You pay:	**$512.10**	**$341.40**

[1] In CT and IL, after a 6-month waiting period, major services pays 50% and remains 50% after year one. [2] Service pricing in ZIP Code 752– and assumes any plan waiting periods and deductibles have been met. Discounts vary by policy year, type of provider, geographic area, and type of service.

NO WAITING PERIODS
PREVENTIVE CARE

ACCESS TO DISCOUNTS
ON HEARING AIDS

OPTION TO ADD
VISION BENEFIT

Premier Plus

With orthodontic care for dependents plus coverage for dental implants under Major Services, this is our most comprehensive plan.

Adds Orthodontics & Dental Implants

Preventive Care Services (includes routine cleaning & exams)	**Policy pays 100% day one**
	After Deductible:
Basic Services (includes simple fillings & extractions)	**Policy pays 35% day one**[1] 65% after policy year one 80% after policy year two
Major Services (includes crowns, root canals, oral surgery, bridges & dental implants)	**Policy pays 10% day one**[1] 40% after policy year one[1] 50% after policy year two
Orthodontic Services (additional $150 lifetime deductible, dependents under age 19 only)	**Policy pays 50% after** 12-month waiting period & deductible $1,000 Lifetime Maximum
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 & major services)
Most Valuable Feature	**Most Diverse Coverage**

All plans pay 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.

Network Pricing Over Time[2]	Retail charge	During policy year:	Premier Plus year one	Premier Plus year two
Molar Root Canal	$1,255.36	You pay:	$512.10	$341.40
Surgical Implant	$2,131.63	You pay:	$972.00	$648.00

[1] In CT and IL: Basic services pays 50% day one. Major services pays 50% after a 6-month waiting period and remains 50% after year one. [2] Service pricing in ZIP Code 752– and assumes any plan waiting periods and the deductible have been met. Discounts vary by policy year, type of provider, geographic area, and type of service.

NO WAITING PERIODS
PREVENTIVE CARE

ACCESS TO DISCOUNTS
ON HEARING AIDS

OPTION TO ADD
VISION BENEFIT

ACCESS TO DISCOUNTS

ON HEARING AIDS

The cost of treatment can often be a prime concern for someone who has hearing loss.

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

Over 60 million Americans ages 12 and older have experienced hearing loss.

—National Council on Aging, December 2024
ncoa.org/adviser/hearing-aids/hearing-loss-statistics/

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**

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

Hearing Discount Example

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

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

[1] 2023 UnitedHealthcare internal data.

Limited discounts available. Administered by UnitedHealthcare Hearing.
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
Eyeglass Frames[3] Once every 12 months	**Network**	Any charge over $150 allowance
	Non-network	Any charge over $75 allowance
Eyeglass Lenses One pair every 12 months (of any type)[3]	**Network**	$10 copay
	Non-network	Any charge over: $40 allowance (Single Vision); $60 allowance (Bifocal); $80 allowance (Trifocal/Lenticular)
and Contacts:		
Contacts Once every 12 months	**Network**	Select Contact Lenses List[4]: $0 Copay Non-Selection Contacts: Any charge over $150 allowance
	Non-network	Any charge over $105 allowance

Optional Vision Benefit Example

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

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

[4] If you choose disposable contacts, up to 6 boxes are included when obtained from an in-network provider.

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

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

Other Details
(all dental plans)

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

This brochure may be used in the following states:

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

Basic Policy Details

State-specific differences may apply. (For CA, see 45586iCA-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

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

All Plans: Basic Services

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

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

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

Premier Plus Plans only

- Implants – covered under Major Services and subject to annual maximum – 1 time per tooth per 60 months
- Orthodontic treatment (covered eligible child under the age of 19) – subject to lifetime maximum and deductible

Calendar Year vs. Policy Year

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

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

Change or Misstatement of Residence (Address)

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

Eligibility

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

Other Details
(all dental plans)

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

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.

Renewability and Termination

The policy is renewable until the earliest of the following:

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

General Exclusions and Limitations

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

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

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

Other Details
(all dental plans)

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

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

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:

- 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).
- Intoxication, as defined by applicable state law in the state where the loss occurred, or under the influence of illegal narcotics or controlled substance, unless administered or prescribed by a doctor.
- Experimental or investigational treatment or complications therefrom. (does not apply in VA)
- Which arise out of, or in the course of your employment for wage or profit (CA, FL, NC – applies if paid by worker's compensation).
- Any act of war, participation in a riot, intentionally self-inflicted bodily harm, or commission or attempt to commit a felony.
- Provided free of charge without this insurance or by a government plan or program.
- Provided by a family member or by someone who ordinarily resides with a covered person. (Does not apply in TX. Does not apply in SD if household member is only provider in 50 mile radius. Someone who ordinarily resides with a covered person does not apply in VA.)
- Received outside of the United States, except for a dental emergency.
- Related to temporomandibular joint, upper and lower jaw bone surgery, or orthognathic surgery (does not apply in MN).
- Teeth that can be restored by other means; periodontal splinting, to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis.
- Maxillofacial prosthetics and related services.
- Orthodontics or dental implants and any related procedure, unless included in your plan.
- To alter vertical dimension and/or restore or maintain occlusion, bite analysis, or congenital malformation.
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal; treatment of malignant neoplasms or congenital anomalies.
- Mouthguards, precision or semi-precision attachments, occlusal guards, bruxism appliances, duplicate dentures, harmful habit appliances, replacement of lost or stolen appliances, or sleep disorder appliances.
- Provided as a result of a prohibited referral (MD only).
- Initial placement of full or partial dentures or bridges and related services, to replace functional natural teeth that are congenitally missing or lost before insurance under the policy is in effect.
- Replacement of full or partial removable dentures, bridges, crowns, inlays, onlays, or veneers which can be repaired or restored to natural function.
- Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error.
- Placement of fixed partial dentures solely to achieve periodontal stability.

Vision Details
(optional benefit)

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

This brochure may be used in the following states:

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

How the Vision Program Works

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

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

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

Eyeglass Frames and Lenses

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

Vision Benefit Exclusions and Limitations

No benefits are payable for the following vision expenses:

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

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.

45586-G-0125

UnitedHealthcare®
Golden Rule Insurance Co.

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

(Please retain this outline for your records.)

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

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

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

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

Dental Benefits

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

PREVENTIVE SERVICES

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

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

C. Problem focused oral evaluations.

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

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

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

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

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

I. Intraoral periapical and intraoral occlusal radiographs image.

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

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

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

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

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

O. Bacteriological and viral cultures.

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

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

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

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

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

BASIC SERVICES

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

B. Simple extractions.

C. Desensitizing medicament.

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

E. Local anesthesia.

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

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

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

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

MAJOR SERVICES (if included)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

R. Protective restoration, covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.

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

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

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

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

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

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

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

Z. Alveoloplasty, not covered for single tooth extractions.

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

BB. Frenectomy/frenuloplasty.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ORTHODONTIC SERVICES (if included)

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

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

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

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

Amount Payable

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

A new deductible amount must be met each calendar year.

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

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

What Is Not Covered

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

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

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

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

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

D. Covered expenses incurred during the waiting period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

W. Maxillofacial prosthetics and related services.

X. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.

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

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

AA. Orthognathic surgery.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TT. Surgical extractions of wisdom teeth.

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

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

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

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

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

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

D. Replacement of crowns, bridges, dentures and fixed or removable prosthetic appliances, implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), inserted prior to plan coverage unless the covered person has been insured under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12-month period, dental services associated with the addition will be covered when the service is a covered expense.

E. Replacement of complete dentures, fixed and removable partial dentures or crowns, implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the dentist. If replacement is necessary because of the covered person's non-compliance, the covered person is liable for the cost of the replacement.

Definitions

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

A. Provision of services.

B. Determination to reform or rescind a policy.

C. Claims practices.

Term of Coverage and Renewability

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

Premium

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